HIV/AIDS:

Building Capacity to Better Serve Your Community

A Guide to Strengthening HIV/AIDS Services

Published by:
U.S. Department of Health and Human Services

MH09D9509

Acknowledgements

This resource primer was developed for the U.S. Department of Health and Human Services (HHS) Office of HIV/AIDS Policy (OHAP) with support secured from the Minority AIDS Initiative Fund. We acknowledge the contributions of the Altarum Institute; L. Michael Gipson, Faithwalk Enterprises, LLC; Educational Services, Inc.; and the Rev. Lora Hargrove Chapman.

Finally, we recognize those unsung heroes who provide HIV/AIDS services daily without fanfare or accolades. Their tireless efforts for the most vulnerable in our society are a model of committed service replicated in community-based and faith-based organizations throughout the United States.

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Friends,

With over 1.2 million Americans living with HIV infection or AIDS, we are at a critical time in the HIV/AIDS epidemic. Two current efforts spearheaded by the Obama Administration have enormous potential to improve the lives of people infected and affected by HIV/AIDS: 1) health reform and its focus on investing in prevention and wellness, improving quality of care, and ensuring affordable, quality health coverage for all Americans; and 2) the development of a National HIV/AIDS Strategy that presents a coordinated and sustainable plan for reducing HIV incidence, increasing access to care, and reducing HIV-related health disparities.

The need for strong new and existing partners at the community level to respond to the HIV/AIDS crisis has never been more important. It is in all of our best interests that viable and indigenous activities, programs, and organizations are at the forefront of the U.S. domestic effort to curb the epidemic. This guide will provide some of the personal assessment, strategic thinking, and organizational background that is essential for getting started in this work, or for taking your existing community programs to the next level if you already serve people infected, affected or at risk for HIV/AIDS.

As a community-based or faith-based organization, your most important partnerships and funding opportunities are at the local, regional, and state level. Establishing strong relationships and collaborating with these entities can help you get essential support and cooperation for effective and sustainable HIV/AIDS activities. The Office of HIV/AIDS Policy can act as an additional resource for you through this guide and the Web site www.AIDS.gov. We encourage you to use these resources and to think critically about how you can best serve your community.

The brief history of the U.S. HIV/AIDS epidemic contained in this guide is a reminder of how far we've come and the many steps required for even moderate progress. The history can be a teaching tool so long as it is informed by the current developments, influences and challenges of the HIV/AIDS epidemic. As you and your colleagues contemplate new or continued involvement in the HIV/AIDS arena, take the time to explore your individual and collective values around what is most important to you and why you wish to do this work. Honest and comprehensive personal and organizational self-assessment will ultimately contribute to your success and sustainability. Our goal through this resource guide is simply to assist you in those efforts.

Sincerely,

Christopher H. Bates
Director
Office of HIV/AIDS Policy
U. S. Department of Health and Human Services

section 1

Providing HIV/AIDS Services

The HIV/AIDS epidemic is real, and you have made a decision to tackle it in your community. You are not alone in your determination, and we are dedicated to providing assistance as you serve those in need. This guide aims to provide a comprehensive picture of the AIDS service field and your potential role in it to help your organization make informed decisions about how and where to begin.

As with many of those involved in this work, you want to make a difference in the lives of those living with or affected by HIV/AIDS. There was a time in this field when the willingness to roll up one's sleeves and get involved was enough. After over 25 years of science, research, and evidence-based practices, we now know that just wanting to help and possessing a compassionate spirit is only the beginning, and not nearly enough. Rudimentary, haphazard training in the health and social service professions that once characterized this field are no longer sufficient, and selectively choosing which populations to serve is unacceptable. The myriad communities at risk are in dire need of educated, thoughtful individuals and organizations dedicated to serving all people. We need leaders in the HIV/AIDS field who are committed to learning, evolving, and developing new skills and sensitivities to best serve their clients and combat this epidemic.

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History of HIV/AIDS Services

When HIV/AIDS first affected the United States in 1981, there were no services, no funds, and a lot of anxiety. No one understood what was happening to those who fell ill, and no one understood how this new disease was transmitted. People infected with HIV were fired from their jobs, displaced from families, and kicked out of their homes. Members of the medical profession were confounded regarding the infection and took extraordinary precautions to protect themselves, going as far as refusing services to patients in need of their care. Even funeral homes sometimes refused to bury the bodies of people with HIV/AIDS. Fear and alarm were rampant.

Governments at every level responded slowly to the growing epidemic, leaving the care to those whose lives, families, and friends had been affected. Misinformation about who could become infected was shared with the public by trusted sources, stigmatizing the disease and leading to widespread public expressions of prejudice against those affected by

HIV. Since many people assumed that infected individuals were members of marginalized populations already stigmatized in the public consciousness, the resulting response was highly detrimental.

Randy Shilt's journalistic account in ***And The Band Played On: Politics, People, and the AIDS Epidemic*** aptly chronicles a frenzied atmosphere, institutional inertia, and a sense of desperation among those affected by HIV/AIDS that characterized the early years of the epidemic. HIV/AIDS has come a long way in almost 30 years, but the specter of those initial years lingers in organizational relationships with the local and federal government. In fact, past stigma and hysteria are often revived whenever the media recognizes that different groups represent the bulk of new HIV cases. The face of the modern HIV epidemic may constantly be changing and met by the public with some degree of compassion, but the original face of AIDS was one constantly beset by fear and neglect.

Paying Proper Respect

Those who first responded to the original crisis included friends, families, and partners of those with HIV/AIDS. They fed, washed, clothed, housed, and advocated for loved ones who were often too weak, demoralized, and ravaged by illness to do so for themselves. There also were members of the social work and medical professions, and faith-based leaders as well, who demanded that institutions and discriminatory administrations meet their missions to care for all people in need, regardless of how they were infected. Given that the communicable routes for HIV transmission were then unknown, the courage of these small groups of often isolated individuals were immeasurable.

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Even as partners, friends, and loved ones died by the hundreds, and eventually the hundreds of thousands, these newly anointed advocates did not end their efforts to address the needs of those with AIDS or at risk for HIV. These individuals started the first AIDS service organizations (ASOs), clinics, hospices, and housing programs. They drafted the first non-discrimination policies in support of people with AIDS and advocated for the funding and research that compose the HIV/AIDS field today.

These advocates provided HIV prevention education in schools, free condoms, and HIV medications to those unable to afford them, and worked for the passage of the Ryan White Care Act (now the Ryan White HIV/AIDS Treatment Modernization Act). They did so with little mainstream support, plenty of associated stigma, and enormous obstacles. The fact that AIDS services are considered a relatively routine aspect of public health is a testament to the sacrifices, tenacity, commitment, and vision of those who risked their own housing, employment, and relationships to build this service arena. These individuals and organizations are more than the past; they are your potential partners, collaborators, and possibly your organizational competitors for resources.

This history is critical for new parties in the HIV/AIDS field to understand because it serves as a backdrop to contemporary conversations about AIDS work, particularly regarding local turf and funding issues. The organizations founded and sustained by those who lost people to AIDS are now institutions that are 10 or 20 years old. No longer maverick agencies of well-intended individuals, they are now established organizations with professional staff and experience. Similarly, many faith-based and mainstream organizations that were once timid or absent in addressing HIV/AIDS in the early years are now more committed to meeting their community needs and actively working to serve those who are living with or affected by HIV/AIDS.

The Importance of Self-Awareness and Values

In addition to understanding the history of HIV/AIDS, it is crucial for both individuals and organizations involved in this work to undergo the regular practice of self-reflection. If you have not engaged in any self-reflection about why you want to do this work and addressed any biases that exist, you may actually do more harm than good. Biases can lead to poor staff attitudes, inconsiderate hours of service, environmental barriers such as location, and perceptions regarding confidentiality. Oftentimes these barriers can restrict client access and make it difficult for organizations to secure the right partnerships.

While you and your colleagues are designing plans to serve your community, take time to reflect. Explore your individual and collective values around topics that go hand in hand with HIV/AIDS work, such as sexual practices, sexual identity, drug use, or racial and ethnic identity. This reflection will serve you and your community well as you go forward.

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Confidentiality

An organization's reputation is made or broken by whether individuals can confide sensitive information to the volunteers and staff without judgment. Your access to this information is a privilege, grounded in your role as a provider. Consumers and communities share private information because they view you as a safe, confidential, and non-judgmental community resource. Violating that trust is not only a transgression of the HIPPA regulations that you are bound by as a health professional, but it will also result in hindered provision of HIV/AIDS care, support, or prevention programs in your community. Without trust, people are less likely to take part in your programs and you find it difficult to obtain the data needed to maintain and track individual or group progress.

Funding and Organizational Capacity

The HIV/AIDS field has come a long way since 1981. The good news is that there are more people interested in combating the epidemic in this country than ever before. There is less HIV/AIDS stigma than a decade ago and more effective treatments are available to prolong the lives of people who are HIV positive. In many parts of the country, it is possible to have public discussions about HIV/AIDS without shame or ridicule. All of these advances are welcome news.

At the same time, organizations still face many obstacles and need a great deal of support. On average, it takes an organization a minimum of two years to become competitive for government funding. Oftentimes, once capacity is built, new organizations have to compete with ASOs who have been offering services to local communities for years. These new organizations are also entering the field at a time when public apathy towards HIV is on the rise and condom use is declining among risk groups. Adolescents and young adults who grew up in the age of AIDS, viewing advertisements projecting images of stable HIV positive individuals often consider HIV a manageable, chronic illness contributing to the absence of public urgency.

As a new organization interested in strengthening the services you provide to your community, you face many challenges, but here are three routes we suggest in building capacity:

1. Establish a track record through volunteer service and strategic alliances with existing organizations to meet gaps in service, or reach underserved populations. Even well-funded, established organizations need volunteers to meet the full breadth of their community obligations. Volunteer service allows individuals and organizations new to AIDS work to develop the skills and sensibilities they need to be effective in this field. One way to accomplish this is by developing relationships with established organizations that have a record of service.

2. Seek start-up funding through public, private, and corporate foundations. The requirements for eligibility are more lenient with foundations, which generally require less documentation, data collection, and evaluation systems and provide most of the grant award upfront. However, foundations are still highly competitive, especially as more organizations feel better-equipped to meet eligibility requirements and other funding prerequisites.

3. Provide services with greater refinement, innovation and professionalism, and utilize evidence-based practices. Increasingly as a prerequisite for funding, grantees are required to have contract-based collaborations and partnerships with organizations to fill gaps in services, strengthen a referral mechanism, and maximize funding. More and more, grantees are encouraged to hire staff with secondary and post-secondary academic degrees in health, education, and social services, instead of following the more liberal hiring practices of the past.

So what exactly do we mean by capacity? The list at the right is a sample of what is typically required of organizations to be eligible and competitive for local, state, or federal funding. However, your organization must bear in mind that even when all of these components are met, funding is not guaranteed. Funds are primarily provided through a government request for applications or proposals on a cyclical basis, anywhere between 1 to 5 years, and the process is highly competitive.

Knowledge about this field has expanded greatly over nearly 30 years of trial and error. Good intentions must be combined with acquisition of skills, sensitivity, knowledge, and understanding of where we have been and where we are going. If you and your group are prepared to meet the demands of this service, the next chapters will assist you in developing some of what you need to get started. The rest will come from your encounters with the people and organizations who work everyday with those infected and affected by HIV/AIDS. Good luck to you as you move forward in your journey.

Capacity Checklist to be eligible and competitive for local, state, or federal funding , organizations should have:

- ☐ A demonstrated history providing services to the target community
- ☐ A demonstrated history of providing open, welcoming, and culturally appropriate services
- ☐ A demonstrated history of collaborations and partnerships with other community-based organizations
- ☐ Documented quality control plans and procedures
- ☐ A computerized client tracking and program monitoring system
- ☐ Ability to collect and analyze client data
- ☐ Security and confidentiality policies, protocols, and procedures
- ☐ Program monitoring review processes
- ☐ Proven target community involvement in program design, planning, and implementation
- ☐ Ability to provide or coordinate continual staff skills training
- ☐ Ability to design and implement qualitative and quantitative evaluation plans
- ☐ A strong referral network for both HIV and non-HIV related social services
- ☐ A 2-month minimum of operational reserve funding (since government funding occurs on a reimbursement basis and can take at least 30 days for reimbursement to occur)

section 2

Your Organization, Your Community

An Introduction to Organizational Capacity and Readiness

Setting up an organization to fulfill your community's unmet needs around HIV/AIDS can be a long, but ultimately rewarding process, and one you can accomplish with the right planning and strategic infrastructure development. This chapter provides a basic road map to help your agency or coalition achieve its goals by establishing a nonprofit eligible for government funding from the local to the federal level.

There are some organizational basics that all community and faith-based organizations must address to be eligible for municipal, state, and federal HIV/AIDS funding. Some funding criteria are specific to each locality, state, or federal agency. Therefore, this chapter only addresses the most general requirements and considerations and should not be considered exhaustive. The following tips assume that you are planning to establish an organization with a 501(c)(3) tax status, a requirement for most government funding. However, this chapter also may be useful for nonprofits that already have their 501(c)(3) tax status for services separate and apart from HIV/AIDS, or existing agencies looking to expand into new HIV/AIDS service areas.

Organizational and Funding Basics

How to Assess Your Readiness

You know you want to do something about the HIV/AIDS crisis in your community. [1] You may even have a tentative plan outlining exactly what type of program you want to launch and the group of people you want to serve. You may have rallied a group of volunteers around your program or agency concept. This is great news, but be prepared for your plans to change depending on what you learn from assessing your readiness and the community's needs. Research is the first step in organizational readiness, not only to determine your capacity, but also to assess whether your interests match the needs within your community, and available funding.

You may find that there are already several successful, established programs in your community that provide the same service that you planned to provide. There might be several other unmet service needs in your

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1 "You" refers to any individual or group interested in establishing a community or faith-based organization eligible for government funding.

community, services more suitable for you to provide and more likely to be funded. Perhaps it isn't a service, but a target population that is underserved. Are you still interested in providing HIV services? Are your volunteers still ready to commit their time to community service in HIV/AIDS? In HIV/AIDS work, community and faith-based organizations have to prepare to be flexible in the services they provide and the people they serve.

GUIDING QUESTIONS

- ☐ What services will my organization provide?
- ☐ Is my idea practical and does it fill an unmet need in the community?
- ☐ Who am I interested in serving and who is already serving them (or not)?
- ☐ Am I best suited to meet my potential target population's needs?
- ☐ If not, how can I get to a point that I have the capacity to meet those needs?
- ☐ Who is my competition? What is my nonprofit's advantage over existing nonprofit organizations?
- ☐ How will I sustain my operation, and can I create a demand for my organization?
- ☐ What skills, education, and experience do I bring to the nonprofit business?
- ☐ What equipment or supplies will I need?
- ☐ What financing will I need?
- ☐ What insurance coverage will I need?
- ☐ Where will my organization be located?
- ☐ Is the planned location accessible for the target population(s)?

If you decide to become a formal nonprofit organization, the checklist at the left provides some baseline considerations you should address first to avoid potential problems later:

While this guide will help you answer some of these questions, additional training and guidance is available through the National Minority AIDS Council's (NMAC) Organizational Effectiveness series. You can get free copies of a series of comprehensive technical assistance manuals and guides on CD-ROM from NMAC's web site (www.nmac.org).

Organizational Tax Status

For the purpose of funding eligibility, there are two nonprofit organizational tax statuses that are important to consider when deciding what kind of agency you plan to form and the services you are interested in providing. These are the 501(c)(3) and the 501(c)(4) classifications.

501(c)(3) A 501(c)(3) is a tax law provision granting exemption from the federal income tax to nonprofit organizations. The three principal classifications of 501(c)(3) organizations are as follows:

A public charity normally receives a substantial part of its income, directly or indirectly, from the general public or from government. If a charity's income is coming from too few sources, the charity is at risk for losing its 501(c)(3) tax status. Therefore, the charity should ensure that its financial support is broad and not limited to a few individuals or donors.

A private foundation, sometimes called a non-operating foundation, receives most of its income from investments and endowments. This income is used to make grants to other organizations, rather than being used for direct services.

A private operating foundation is a private foundation that devotes most of its earnings and assets to the conduct of its tax exempt purposes, rather than to making grants to other organizations.

501(c)(4) Agencies with a 501(c)(4) also are tax-exempt nonprofit organizations, but they cannot receive tax-deductible donations like a 501(c)(3). This designation is for nonprofit organizations that further social welfare or public good and want to use lobbying as one of their activities.

While both types of organizations must be run as nonprofits that do not benefit private stakeholders, and both are exempt from paying federal income tax, there are differences between them. The difference lies in an organization's political involvement and the ability to offer tax deductions for donations. A 501(c)(3) is limited in its political lobbying abilities, but donations made to 501(c)(3) agencies are tax deductible. Donations to a 501(c)(4) are not tax deductible, but 501(c)(4) charities can engage in political campaign activity, so long as it is not the organization's primary activity.

Determining whether or not to become a formal nonprofit, a civic organization or association, or a for-profit business is one of the most significant decisions your organization will have to make. Your agency's tax exempt status determines the legal structure for your organization, the roles and responsibilities of your board and staff, your record keeping and accounting systems, and the taxes you are accountable for and those from which you are exempt.

The majority of the government funding resources discussed in this guide are directed toward nonprofit entities with a 501(c)(3) tax status. Therefore, this chapter focuses on establishing a 501(c)(3) organization.

Basic Infrastructure Considerations

A nonprofit requires certain basic infrastructure to be considered fully operational. The following is a checklist for establishing your basic organization infrastructure, including several core capacities that are specific to HIV/AIDS services:

Mission Statement: A mission statement describes an organization's values, the services offered to clients, and the group(s) of clients who will benefit from these services.

Board of Directors: Most states require that you recruit at least three board members to establish a nonprofit board. There is no cap on the number of members a nonprofit board can have, but it should be a manageable body that can make quick and efficient decisions. The main role of a board is to provide guidance and oversight to an agency's executive leadership, specifically the Executive Director or CEO, who in turn is responsible for guiding and executing board approved directives with an agency's staff. The board is legally responsible for the financial decisions of an organization, so it is recommended that an organization get board insurance to protect the personal assets of individual board members from any organizational liability in the case of a lawsuit. While a nonprofit board can begin as a community advisory committee in the exploratory and planning phases of a nonprofit, prior to incorporation, a board should not be confused with an advisory council. A board is legally responsible for a nonprofit, while an advisory council's role is typically to provide a channel for direct community involvement in nonprofit policies, practices, and procedures, without assuming legal responsibilities.

CORE INFRASTRUCTURE

- ☐ Mission Statement
- ☐ Board of Directors
- ☐ Incorporating
- ☐ Tax Exemptions and Permits
- ☐ DUNS Number
- ☐ Employer/Taxpayer Identification Number (EIN/TIN)
- ☐ State Single Point of Contact (SSPOC) Letter or Registration Receipt (if applicable)
- ☐ Business Plan
- ☐ Legal Representation
- ☐ Accounting Services
- ☐ Insurance
- ☐ Roles and Responsibilities
- ☐ Policy and Procedures Manual
- ☐ HIPPA Compliance
- ☐ Fiscal Agents and Sponsorship
- ☐ Physical Space

Structurally, boards generally have a Board Chair or Board co-Chairs responsible for publicly representing an agency's board and for communicating the board's interests to the Executive Director. Other key board officer positions include treasurer, secretary, governance, and other officers responsible for chairing specific committees. Boards generally have chaired committees, each focused on a specific aspect of an organization (e.g., program, governance, development, community relations, etc.). Board members usually serve 1 to 2 year renewable terms and are recruited on a staggered schedule to maintain stability by avoiding a simultaneous mass exit of an organization's historical memory. Strategic board recruitment is crucial to both a board and an organization's success. While it may be easier to identify willing board members from the social and public service sectors, diversity in board composition is vital to an organization's overall success and reduces the likelihood of conflict of interest issues among individual board members. It is also vital to include people living with HIV/AIDS on your board.

Incorporating: All nonprofit entities must file their board approved articles of incorporation with their state registry. Some states also require that board bylaws be included with the articles of incorporation. Depending on the state and the services provided, some cities may require additional business licenses, certifications, and report filings as part of their checklist of assurances. For frequently asked questions about incorporating, visit the Small Business Administration (SBA, www.sba.gov).

Tax Exemptions and Permits: An organization must apply for 501(c)(3) status with the Internal Revenue Service (IRS, www.irs.gov/charities) to be eligible for federal tax exemption. After getting approved as a 501(c)(3), an organization can then apply for tax exemption at the state level from their State Attorney General's office or Secretary of Commerce. Your organization may also qualify for a property tax exemption; a visit to your local municipal tax assessor will determine your agency's qualifications for this exemption.

DUNS Number: For federal funding, an organization will need to have a Data Universal Numbering System (DUNS) Number. This number allows the federal government to identify organizations under grants and cooperative agreements. The federal government requires that your organization and/or any of its sub-units have this number. Visit www.whitehouse.gov/omb/grants/duns_num_guide.pdf for more information.

Employer/Taxpayer Identification Number (EIN/TIN): An organization will also need to have an Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

State Single Point of Contact (SSPOC) Letter or Registration Receipt (if applicable): Some federal applications require organizations to inform

a central contact person or agency in their state that they are applying for a specific grant. This helps states to keep track of what kinds of funds are being requested and coordinate partnerships within a state. Visit www.whitehouse.gov/omb/grants/spoc.pdf to find out the requirements in your state.

Business Plan: Even though you may not be establishing a for-profit business, a start-up nonprofit should still create a business plan to assess your organization's resource requirements, market needs, competitors, budget projections, and scope of work. The Small Business Administration's Small Business Planner (www.sba.gov/smallbusinessplanner) has tools available for writing a business plan.

Legal Representation: To establish its articles of incorporation and deal with on-going contractual needs, a start-up nonprofit should retain legal counsel. The attorney should be experienced in practicing nonprofit or tax law, and not a paralegal or other type of legal representative. Once an agency has been approved for tax-exempt status, the attorney could be eligible for tax deductions for providing pro bono legal services to your agency. An organization's legal counsel can also be a board member, but an agency may want to consider any potential conflicts of interest for an attorney serving in this dual capacity.

Accounting Services: Many organizations cannot afford to have a full-time certified public accountant (CPA) or chief financial officer when getting started. It is still, however, important that an accountant help set-up and maintain a standard bookkeeping system. Many accounting firms and independent accounting consultants will set-up and maintain an organization's books on a contractual basis. In addition to bookkeeping, budget maintenance, and meeting financial reporting requirements, an organization will want to have an accountant to conduct financial audits. Most nonprofits have to conduct at least one comprehensive financial audit every 2 years, since this is a requirement for many public and private foundations.

Insurance: Board, property, and liability insurance are just the basic insurances an organization needs if providing HIV/AIDS services; most of these insurances are required for government funding. Additional insurance, such as employment compensation insurance, will also be legally required once your organization is at the point of hiring staff. An insurance agency can help an organization determine what kind and how much insurance it needs when getting started.

Staff: The HIV/AIDS field historically has trained and groomed people from the grassroots up to executive positions, with little previous training in health education, public health, or human services. That has changed as HIV/AIDS care has become a more competitive, technical field.

ROLES and RESPONSIBILITIES

Partners An MOA/MOU should each organization's roles and responsibilities:

- ☐ Clearly define each organizations' roles and responsibilities
- ☐ Specify a start and end date for the agreement
- ☐ Include any documentation and monitoring expectations
- ☐ Identify primary and secondary points of contacts for both organizations
- ☐ Provide brief meeting, communication, and dispute resolution plans
- ☐ Be reviewed by each organization's legal counsel and endorsed by senior administrators
- ☐ Be reviewed annually by both organizations

Staff For functional and efficient operations and to be eligible for funding organizations, should:

- ☐ Document position descriptions for all staff
- ☐ Document signed confidentiality agreements for all staff, volunteers, and board members
- ☐ Document expectations and, when appropriate, position descriptions for all volunteer staff and volunteer board positions
- ☐ Document police clearance or FBI background checks for any positions working with clients under age 18
- ☐ Document quarterly, semi-annual, or annual staff performance evaluations
- ☐ Obtain resumes for all full and part-time staff positions
- ☐ Establish locked physical filing systems and password protected electronic systems
- ☐ Document baseline organizational training plans for all staff and volunteers, particularly trainings on organizational policies and practice, cultural competency, and client confidentiality
- ☐ For organizations handling medical records, document new staff trainings on Health Insurance Portability and Accountability Act (HIPAA) compliance

The staff you hire depends on the level of expertise and experience needed to adequately serve your community. Staff members need to be trained - and preferably credentialed - in public health, health communication, social service delivery, and cultural competence. Staff should also be representative of your target communities, including people living with HIV/AIDS. It is an organization's responsibility to ensure high quality services by establishing training plans for staff and taking advantage of training and capacity building opportunities as needed. Many government agencies offer capacity building and service delivery trainings on a variety of topics. HIV/AIDS is a field that is constantly changing due to ongoing innovations and new scientific knowledge. Organizations should regularly check federal government Web sites and publications to stay abreast of changing federal policies, priorities, and new initiatives.

Roles and Responsibilities: Many organizations begin with a volunteer staff of committed individuals. To be more competitive and to ensure staff capacity to fulfill program goals, staff-limited organizations may want to partner with larger, more established organizations to augment their organizational capacity. In this case, it is important to establish the roles and responsibilities of each partner organization. Organizations should have a written Memorandum of Agreement (MOA) or Memorandum of Understanding (MOU) that outlines each organization's roles and responsibilities. A sample MOU is included in Appendix F to guide you.

Equally important to outlining the roles and responsibilities between partners is documenting staff roles and responsibilities. In a small nonprofit, it is common for a limited number of staff members to wear many hats to get the job done. There still need to be clear roles and responsibilities that distinguish agency expectations of board members, volunteers, senior administrators, and the frontline staff. There also are responsibilities every organization must fulfill to ensure client safety and confidentiality.

Policy and Procedures: All organizations with staff, volunteers, or both need a written policy and procedures manual. Some types of service, including HIV counseling and testing services, require specialized policy and procedures manuals for staff and an additional quality assurance manual outlining controls, evaluation assessments, and monitoring procedures. Usually these policies and procedures are determined by legal regulations at the local, state, and/or federal level and are required to be implemented as a condition of a grant award. Organizations unsure of how to draft such a manual or lacking technical expertise should contact the funding agency or their local health department for examples of manuals in use.

HIPPA Compliance: An individual's health information is privileged and legally protected. Since 1996, health service providers have had additional legal responsibilities for protecting the privacy of their clients'

medical information. The Health Information Portability and Accountability Act (HIPPA) has rules regarding the security and management of clients' health records, disclosure of clients' medical information or health status, and offers stronger, legally bound confidentiality assurances to recipients of health services.

There is often confusion in the health field about which client health information is private or confidential and under what circumstances organizations are liable for staff breaches in confidentiality. HHS has a number of resources to help organizations like yours be HIPPA compliant. To determine whether or not you are HIPPA compliant, or to learn how to become compliant as a provider, visit the federal Web sites listed in Appendix B and be sure to access your state or local health department for information on state laws and regulations.

Fiscal Agents and Sponsorship: Your organization may need to have another agency serve as a fiscal agent or sponsor. Fiscal agents are ideal for organizations that have not acquired the necessary resources to establish a fully operational non-profit and need time to grow. They also may be useful in providing an organization with the essential skills and capacities to manage finances. If your project plans are only for a short time and a formal non-profit entity is not needed, a fiscal agent may be the most ideal situation for your group. As previously described, both organizations need to draw up an MOA/MOU outlining a timeframe, roles and responsibilities, and administrative cost allocations (fiscal agent support is generally supplemented through administrative fees and costs charged to your organization). Some fiscal agents provide in-kind support and do not charge administrative overhead to short-term or new start-up non-profits. In either case, a legal agreement should be developed and approved by both parties and their legal counsel.

Physical Space: Contrary to popular belief, it is not necessary to own your own building to be eligible for government funding! Start-up organizations often rent space from other organizations until they have the capacity to rent or own a separate dwelling. Multiple smaller organizations may also rent a single large office and share administrative costs such as a receptionist, printer, copier, and even accounting services to maximize resources. Geographic location, availability of parking, and space for confidential testing or discussions are just a few things to consider when looking for space.

Choosing the Right Program for Your Organization

Community Needs Assessment

There are probably already HIV/AIDS services available in your community. There also are most likely gaps in services available or target populations receiving services and support. Local, state, and federal agencies all require that an organization use local community needs assessment and epidemiological surveillance data to decide who they will serve and how.

STEPS IN A COMMUNITY NEEDS ASSESSMENT:

1. **Choose a target population and a geographic location or setting**
2. **Review available HIV/AIDS surveillance data**
3. **Review other HIV/AIDS related datasets**
4. **Community resource and service mapping**

An organization can conduct its own needs assessment to determine what HIV/AIDS services are available for a particular target group in a specific geographic area. There are several government and nonprofit resources available online that can assist you in planning and implementing a community needs assessment. Here are some basic steps your organization can take to identify a group in your community that you will serve, and the group's specific HIV/AIDS service needs:

Choose a target population and a geographic location or setting: Narrow your research to a target population in a certain community or setting. For instance, by choosing African American women of childbearing years who live in Ward five or within the Fayetteville community, you narrow the search to a manageable size and are more likely to identify gaps in services or resources for this group. Instead of a geographic region or a group of people, your organization might choose to research services for a group already in a certain setting such as the local jail, detox facilities, high schools, or retirement communities, among others.

Review available HIV/AIDS surveillance data: Federal, state, and many large city health agencies release HIV/AIDS surveillance reports outlining the HIV and AIDS rates, incidence, and prevalence in a geographic area. Local epidemiology surveillance reports are available online through your city or state health department. See Appendix A for links to federal HIV/AIDS surveillance reports and other useful datasets.

Review other HIV/AIDS related datasets: Data on sexually transmitted diseases and substance abuse available at the local health department can provide powerful arguments for defining a group or community's risk for HIV/AIDS. Reproductive health data on abortions and unintended and teenage pregnancy rates can also help crystallize a community's risk behaviors, as can local incarceration rates, particularly for drug and alcohol related offenses. STDs, drug use, and unintended pregnancy are all predictors and co-factors for HIV infection. National nonprofit and advocacy groups often compile population specific data and release them as fact sheets, issue briefs, white papers, and policy position statements that can also help you understand your target group and their needs. (See Appendix A)

Community resource and service mapping: What are the resources available to support the target population in your community? What programs and organizations have dedicated resources to serve your chosen group? What HIV/AIDS services (e.g., care, housing, psychosocial support, prevention, treatment) and HIV/AIDS related co-factors (e.g., mental health, drug treatment, poverty prevention programs) exist in your community?

If a community resource map process has not been implemented in your area in the last 3 years by another agency, it may be an ideal time for you to implement this process. A guide published by the National Center for Secondary Education and Transition (NCSET) provides a step-by-step process on community resource mapping. Though the NCSET guide is focused on youth with disabilities, the guide is generalizable for any community resource mapping process. You can access NCSET's guide at www.ncset.org/publications/essentialtools.

Mobilizing Your Community

What is community mobilization?

Community mobilization engages all sectors of the community in an effort to address issues of concern to everyone. It brings together policy makers and opinion leaders, local, state, and federal governments, professional groups, religious groups, businesses, and individual community members. Community mobilization empowers individuals and groups to take action and facilitate change.

Part of the process includes mobilizing necessary resources, disseminating information, generating support, and fostering cooperation across public and private sector groups in the community. Anyone can initiate a community mobilization effort; all it takes is a person or a group to start the process and bring others into it.

Why mobilize the community?

- Infuse new energy into an issue through community buy-in and support
- Expand the base of community support for an issue or organization
- Help a community overcome stigma and denial of a health issue
- Promote local ownership and decision-making
- Increase cross-sector collaboration and shared resources
- Limit competition and redundancy of services and outreach efforts
- Provide a focus for prevention planning and implementation efforts
- Create public pressure to change laws, polices, and practices — progress that could not be made by just one individual or organization

- Increase access to funding opportunities for organizations and promote long-term, organizational commitment to social and health-related issues

Who will you need to mobilize in the community?
For community mobilization efforts addressing HIV/AIDS, it will be most effective to gather the support of those who interact with and influence groups most at-risk for HIV/AIDS. They include:

- People living with and affected by HIV/AIDS
- Heath Care providers
- Community-based organizations
- Faith-based organizations
- Local and state policy makers and opinion leaders

Partnering with Community-Based Organizations to Address HIV/AIDS
Addressing HIV/AIDS will not be possible without significant buy-in, support, and involvement from community leaders. It is important for organizations to build support for efforts that reach out to and partner with local and state health departments, community leaders, and organizations within affected communities. Their involvement is essential for any type of coordinated response to spikes in HIV infection rates, expanding clinical and laboratory services, and for enhancing health promotion interventions.

Without community buy-in, there can be no community partnerships. These groups must be equal partners in the process and can provide necessary linkages between community, federal, state, and local efforts. The involvement of community-based leaders and organizations can:

- Facilitate communications that are more effective
- Restore, build, and maintain trust in affected populations
- Improve access to and utilization of testing, treatment, and health promotion services
- Ensure the development of culturally competent interventions
- Encourage participation of community members to build capacity to address HIV/AIDS

How can community-based organizations get involved with HIV/AIDS activities?

- Contact policy makers at local and state level and inform them about the increase of HIV/AIDS in the community and ongoing efforts to address the problem
- Invite a community leader, policy maker, or a guest speaker who is involved in HIV/AIDS to speak during a community-wide event
- Write a "letter-to-the-editor" for local newspapers requesting that they inform their readers about the importance of preventing and treating HIV/AIDS
- Partner with neighborhood hospitals, clinics, pharmacies, AIDS service organizations, and STD clinics to start a community-wide initiative to raise awareness about HIV testing, treatment, and prevention
- Collaborate with other community organizations to determine how a coalition can convey the HIV/AIDS testing and prevention messages to their constituents
- Provide frequent progress reports and updates to the community about the current status of HIV/AIDS

Additional details and a phased approach to community mobilization can be found in Appendix D.

section 3

Partnering with the Federal Government to Prevent HIV

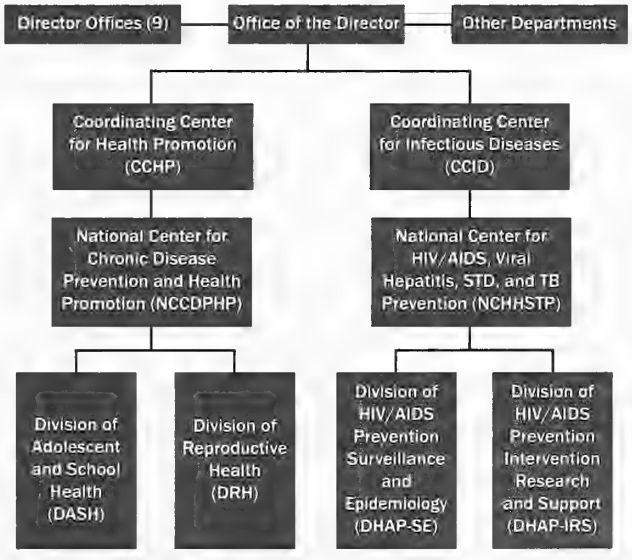
An Introduction to the Centers for Disease Control and Prevention (CDC)

An important part of building your organizational capacity is learning about major federal HIV/AIDS initiatives and programs, as well as how you can participate in these programs locally and even receive funding. The CDC (www.cdc.gov), a part of the Department of Health and Human Services, focuses on developing, supporting, and disseminating scientific-based solutions to protect the health of people in the United States, and around the world. The CDC is the primary federal agency for conducting and supporting public health activities, including coordinating prevention efforts for HIV.

Key Programs and Initiatives

CDC has two major HIV/AIDS related coordinating centers- the Coordinating Center for Health Promotion (CCHP) and the Coordinating Center for Infectious Diseases (CCID). Within each of these Coordinating Centers are National Centers whose programmatic focus is on HIV/AIDS.

HIV/AIDS Related CDC Offices



Coordinating Center for Infectious Diseases (CCID) is the national authority on the nature of and response to HIV/AIDS in the United States. CCID is home to the:

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) is responsible for public health surveillance, prevention research, and programs to prevent and control HIV/AIDS, other sexually transmitted diseases, viral hepatitis, and tuberculosis. Center staff work in collaboration with partners at the community, state, national, and international level.

Coordinating Center for Health Promotion (CCHP) plans and directs national programs around disease prevention and health promotion in the areas of chronic disease, birth defects, disabilities, and genomics. One of CCHP's centers is the:

National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) is charged with working to prevent and control chronic diseases. The center conducts studies to better understand the causes of these diseases, supports programs to promote healthy behaviors, and monitors the health of the nation through surveys. The center is responsible for programs on topics related to HIV/AIDS such as healthy motherhood, women's health, and adolescent health. Critical to the success of NCCDPHP's efforts are partnerships with state agencies, community-based organizations, the private sector, and other federal agencies.

CDC • Where to Start and How to Get Involved

Community Planning Groups

CDC encourages community and faith-based organizations to get involved in HIV prevention activities through participation in HIV Prevention Community Planning Groups (CPGs). Fifty-nine state and local health departments that are CDC grantees coordinate these CPGs, which have three major goals:

- Support broad-based community participation in HIV prevention planning
- Identify HIV prevention needs in each jurisdiction
- Ensure that HIV prevention resources target priority populations and interventions set forth in the comprehensive HIV prevention plan

It is crucial that community and faith-based organizations take the time to find out about and participate in their jurisdiction's Community Planning Group, including meeting time and location, nominations process, and current priorities and previous milestones. Participation and contribution to CPG initiatives will show your interest and experience in helping to reduce HIV incidence in your local area, as well as help you influence key decisions on programming and policy. This is important as you seek to apply for funds in HIV prevention services.

Applying for CDC funding

CDC provides direct funding to health departments, as well as some direct funding to community-based organizations. At the community level, CDC funds a small number of organizations that replicate the science-based programs CDC has endorsed through the Diffusion of Effective Behavioral Interventions project (DEBI, www.effectiveinterventions.org). After you have started working with your local CPG and been successful at getting local funding, your organization may be in a position to pursue this CDC funding. If that is the case, make sure to familiarize yourself with the DEBI programs and their evidence base. Your organization should also ask some other important questions, including:

1. Decide if you are ready to work with the CDC

- ☐ Do you know the CDC centers that work on HIV/AIDS and what each has to offer?
- ☐ Is a particular grant opportunity appropriate for your organization?
- ☐ Have you assembled and maintained current project and community data for planning?
- ☐ Have you reviewed CDC's current funding announcements and planned a strategy?
- ☐ Do you have resources, including a writing team, to prepare an application?
- ☐ Can you write a fully responsive application?
- ☐ Are you ready to have your application peer-reviewed?

2. Pre-plan and be ready to respond to a funding opportunity

- ☐ Does your organization have a clear mission that can help focus your search for resources?
- ☐ Do you value the importance of building and working in coalitions, partnerships, and networks?
- ☐ Have you done a literature search of needs, science and evidence-based models, standards for service delivery, and best practices?
- ☐ Are your mission and plan driven by a community needs assessment?
- ☐ Can you create or use an existing community needs assessment to help you?
- ☐ Is there a local advisory group already central to your planning?

3. Get Data CDC is a world-class resource for data on many public health and epidemiologic conditions and topics, including HIV and AIDS. These data will be helpful to you when identifying issues that affect your target population and/or geographic area.

4. Submit the most competitive application for funding CDC has a wealth of information and tools to walk you through various stages of planning for and preparing a competitive application. Go to www.cdc.gov/about/business/funding.htm to learn more about current opportunities and tools to help you prepare your application.

An Introduction to the Substance Abuse and Mental Health Services Administration (SAMHSA)

This section provides an overview of SAMHSA (www.samhsa.gov), the lead federal agency for the prevention, treatment, and surveillance of mental health and substance abuse issues. This section also offers tips on how to access SAMHSA information and resources for your organization.

Key Programs and Initiatives

SAMHSA's vision as an agency is "A Life in the Community for Everyone." This vision is based on the premise that people of all ages, with or at risk for mental or substance use disorders, should have the opportunity for a fulfilling life that includes a job, a home, and meaningful personal relationships with friends and family.

SAMHSA's Centers

Center for Mental Health Services (CMHS) leads the federal government in addressing mental health infrastrucutre capacity of health care providers, and the service needs of mental health consumers. CMHS helps states improve and increase the quality and range of treatment, rehabilitation, and support services for people with mental health disorders, their families, and communities.

People with HIV/AIDS may have psychiatric complications such as AIDS-related dementia or other mental health disorders. As part of its work, CMHS administers HIV/AIDS programs that focus on prevention, education, and delivery of mental health services for persons living with HIV/AIDS.

SAMHSA's HIV/AIDS and Hepatitis Strategic Plan

In order to address the behavioral health needs of people living with HIV and AIDS, each of SAMHSA's three centers has specific HIV/AIDS programs and funding opportunities. The goals of SAMHSA's HIV/AIDS and Hepatitis Programs are:

- To make an impact on curbing the nation's HIV/AIDS epidemic
- To disseminate knowledge about the mental health aspects of HIV/AIDS
- To identify effective approaches for delivering mental health services to people living with HIV/AIDS and disseminate these findings to health care providers
- To improve the health outcomes of people living with HIV/AIDS who also have a mental health and/or substance use disorder

A major activity outlined in the HIV/AIDS Strategic Plan is to increase the number of SAMHSA grantees that provide HIV testing. All three SAMHSA centers also have a role in managing portions of the Minority AIDS Initia-

Approximately [56,300]* Americans annually become infected with HIV. Of these, about one-third of those persons are co-infected with viral hepatitis from similar modes of transmission. Only a small percentage of individuals at risk for transmission of these diseases resulting from a substance abuse and/or mental health disorders receive appropriate prevention and treatment services

SAMHSA/CSAT

**Statistic from CDC, www.cdc.gov/hiv/topic/basic, accessed 11/11/08*

tive (MAI), a federal initiative that provides funds to community-based organizations and others to address HIV/AIDS issues that disproportionately impact minority communities.

Center for Substance Abuse Prevention (CSAP) works with states and communities to develop comprehensive substance abuse prevention systems. CSAP identifies and implements science and evidence-based program models to prevent, reduce, and treat substance abuse in schools, workplaces, communities, and within families and social networks.

CSAP's HIV-specific initiatives include:

- Targeted Capacity Expansion Initiatives for Substance Abuse Prevention
- HIV Prevention (HIVP) in Minority Communities: Substance Abuse, HIV, & Hepatitis Prevention for Minority Populations and Minority Reentry Populations in Communities of Color

Center for Substance Abuse Treatment (CSAT) works with states and community groups to improve and expand substance abuse treatment services that target those in recovery. CSAT's HIV/AIDS work is primarily treatment and early intervention services, with the specific intent of reaching out to persons at high-risk for HIV, or who are HIV-positive and have been historically underserved by substance abuse treatment programs. At the same time, CSAT addresses the capacity of existing substance abuse service providers and networks to identify and provide early intervention services to HIV-positive or at-risk persons they are already serving. Further, the 25 states with the highest rate of new HIV cases must set aside 5% of their Substance Abuse Prevention and Treatment Block GrantBlock Grant for HIV prevention activities.

In addition to these three centers, SAMHSA has the Office of Applied Studies (OAS), which provides data on the impact of mental health disorders and substance abuse, as well as the impact and performance of programs that address these issues.

SAMHSA • Where to Start and How to Get Involved

If you want to link to SAMHSA's purpose, strategic plan and programs to further your HIV/AIDS work, there are specific HIV/AIDS initiatives you should review, learn more about and keep on your radar. Knowing who SAMHSA funds in your area may give your organization an opportunity to obtain technical assistance from or partner with those local and national organizations.

Remember: SAMHSA's HIV/AIDS Strategic Plan reaches across many of its substance abuse and mental health programs. Applying for funds to address substance abuse or mental health in your community is also addressing and supporting HIV/AIDS prevention, treatment, and access to services for persons impacted by the disease.

1. Decide if you are ready to work with SAMHSA

- ☐ Do you know SAMHSA's three Centers and what each has to offer?
- ☐ Is a particular grant opportunity appropriate for your organization?
- ☐ Have you assembled and maintained current project and community data for planning?
- ☐ Have you reviewed SAMHSA's funding announcements and planned a strategy?
- ☐ Do you have resources, including a writing team to prepare an application?
- ☐ Can you write a fully responsive application?
- ☐ Are you ready to have an application peer-reviewed?

2. Pre-plan and be ready to respond to a funding opportunity

- ☐ Does your organization have a clear mission that can help focus your search for resources?
- ☐ Do you value the importance of building and working in coalitions, partnerships, and networks?
- ☐ Have you done a literature search of needs, science and evidence-based models, standards for service delivery and best practices?
- ☐ Are your mission and plan driven by a community needs assessment?
- ☐ Can you create or use an existing community needs assessment to help you?
- ☐ Is there an advisory group already central to your planning?

3. Get Data Do you know that substance abuse and mental health data can keep your staff and programs up-to-date and ensure that your HIV/AIDS programs are relevant? SAMHSA's Office of Applied Studies (OAS) collects and reports data on behavioral health practices and issues to assist patients, treatment providers, and policy makers in making informed decisions regarding prevention and treatment. OAS has published studies on alcohol, tobacco, marijuana, and other drugs, drug-related emergency department episodes and medical examiner cases, and the nation's substance abuse treatment system. Reports are issued from the following major OAS data systems:

- National Survey on Drug Use & Health (NSDUH) Series
- Drug Abuse Warning Network (DAWN) Series
- Drug and Alcohol Services Information System (DASIS) Series
- National Survey of Substance Abuse Treatment Services (N-SSATS)
- Treatment Episode Data Set (TEDS)
- Substance Abuse Treatment Facility Locator

SAMHSA is a great resource for data on mental health and substance abuse nationally and locally. This information may be help you identify the main issues that impact your targeted population and area/jurisdiction. HIV/AIDS, substance abuse, and mental health are related and those links are reflected in the data.

4. Submit the most competitive application for funding SAMHSA has a wealth of information on its Web site and tools to walk you through the application process. Developing Competitive SAMHSA Grant Applications is a manual created to help grantees acquire the skills and resources needed to plan, write, and prepare a competitive grant application for SAMHSA funding. You can find the manual online at www.samhsa.gov/Grants/TA/index.aspx.

section 4

Partnering with Government to Care, House and Support People with HIV/AIDS

An Introduction to the Health Resources and Services Administration (HRSA)

HRSA (www.hrsa.gov) is the federal agency charged with improving access to health care services for people who have no medical insurance, are isolated, or medically vulnerable. HRSA provides technical assistance and financial support to health care providers in every state and territory. HRSA grantees in turn provide health care to people who are uninsured, people living with HIV/AIDS, pregnant women, mothers, and children.

HRSA has six bureaus, with one dedicated to HIV/AIDS – the HIV/AIDS Bureau (HAB). HAB is responsible for administering funds authorized by Congress through the Ryan White HIV/AIDS Treatment Modernization Act of 2006.

The Ryan White HIV/AIDS Treatment Modernization Act of 2006 (previously known as the Ryan White CARE Act) is a federal law that funds services for people living with HIV/AIDS who cannot afford to pay for the care they need. Ryan White helps cities, states, and local community-based organizations pay for HIV/AIDS medical and support services, including medication. The program also pays for care that is not covered by other programs like Medicaid and Medicare. The primary goal of Ryan White is to get those who are HIV positive the care they need early on, and provide support to keep them healthy over the course of their lives.

The majority of Ryan White funds are given to cities and states. Many decisions about how to use the funds are made by local planning councils and state planning groups. These planning groups work as partners with local government.

Five Major Parts of The Ryan White HIV/AIDS Treatment Modernization Act

Part A provides funding to metropolitan areas hardest hit by the HIV epidemic

Part B provides funding to the 50 states, the District of Columbia and U.S. territories for comprehensive primary health care. It includes the AIDS Drug Assistance Program (ADAP)

Part C provides direct funding to community-based, early intervention services

Part D provides funding to organizations supporting health services for infants, children, youth, and women with HIV and their families

Part F (there is no Part E) includes the Special Projects of National Significance (SPNS) Program, innovative models of care, AIDS Education and Training Centers (AETC) training for health care providers, the HIV/AIDS Dental Programs, and the Minority AIDS Initiative (MAI) to reduce racial/ethnic disparities in service access and outcomes

A full description of Parts A through F of the Ryan White HIV/AIDS Treatment Modernization Act can be found in Appendix G.

Minority AIDS Initiative Through the Ryan White HIV/AIDS Treatment Modernization Act of 2006, funds have been awarded under the Minority AIDS Initiative (MAI) to improve the quality of care and health outcomes in communities of color disproportionately affected by the HIV epidemic. The MAI dollars are distributed to states and across eligible metropolitan areas based on the number of ethnic minority AIDS cases in each region. Funds are to create, modify, or expand culturally and linguistically appropriate HIV care services for these communities.

Key Legislative Components MAI funds were allocated by Congress for a specific purpose, so they have a special Condition of Award (COA). Grantees must document the use of MAI funds separately from other Ryan White funds, create an MAI Plan, and complete a separate mid-year and final progress report. Sub-recipients accessing MAI funds through their local Eligible Metropolitan Area (EMA) or state HRSA grantee may be asked to show evidence of the following:

- Compliance with the MAI Condition of Award and related requirements
- Progress in meeting planned objectives
- Potential grantee technical assistance needs
- Type and quantity of services delivered and demographics of clients served
- Improvements in access and health outcomes

HRSA • Where to Start and How to Get Involved

If you want to link to HRSA'S Ryan White HIV/AIDS Program to further your HIV/AIDS work, it is important to familiarize yourself with the five parts of the Ryan White Treatment Modernization Act, the granting/subcontracting policies of the Eligible Metropolitan Area (EMA)or Transitional Grant Area (TGA) of which you are a part, and the core medical service or support service you anticipate providing. The information described in the previous section may serve as a reference guide while your organization seeks to obtain direct funds, technical assistance, or partnerships with local and national organizations already funded to do this work.

1. Decide if you are ready to work with HRSA or a local HRSA grantee

- ☐ Do you know the five Parts of the Ryan White Act and what services each has to offer?
- ☐ Have you reviewed HRSA or your local HRSA grantee's Ryan White funding opportunity announcements or notice of funding availability?
- ☐ Is a particular grant opportunity appropriate for your organization?
- ☐ Have you received appropriate training, licensure, or certification to provide the core or support services you want to apply for?
- ☐ Do you have resources, including a writing team, to prepare an application?
- ☐ Can you write a fully responsive application?
- ☐ Are you ready to have an application peer-reviewed?

2. Pre-plan and be ready to respond to a funding opportunity

- ☐ Does your organization have a clear mission that can help focus your search for resources?
- ☐ Do you value the importance of building and working in coalitions, partnerships, and networks?
- ☐ Have you done a literature search of needs, science and evidence-based models, standards for service delivery and best practices?
- ☐ Are your mission and plan driven by a community needs assessment?
- ☐ Have you obtained the appropriate licenses or certifications to provide the core or support services you want to provide?
- ☐ Are there additional local, county, or state requirements for providing those services?
- ☐ Is there a planning council or local advisory group central to your planning?

3. Get Data

HRSA has valuable and readily available data on Ryan White grantees and their programs; statistics on grant dollars by program and geographic location; and a search engine to locate grantees by program and location. These data links on HRSA's Web site can be found in Appendix A.

4. Submit the most competitive application for funding

HRSA has a wealth of information and tools on its Web site to help you determine whether or not your organization is eligible to receive direct funding. Visit www.hrsa.gov to review current funding opportunities and instructions to apply.

Most community and faith-based organizations providing Ryan White supported care to persons living with HIV/AIDS receive funding directly from the HRSA grantee in their EMA/TGA. In order to receive funding announcements and review funding requirements, contact your EMA/TGA grantee directly. Get to know all of your community partners, state and local health departments, and what the Ryan White Program is already funding in your area.

An Introduction to HOPWA – A Program of the Department of Housing and Urban Development (HUD)

To address housing needs for low-income persons who are living with HIV/AIDS and their families, the Department of Housing and Urban Development (HUD) manages the Housing Opportunities for Persons with AIDS program (HOPWA, www.hud.gov/offices/cpd/aidshousing/index.cfm). HOPWA is the only federal program dedicated to the housing needs of persons living with HIV/AIDS and their families. Funds are distributed to states and cities based on the number of AIDS cases they have then made available as part of the area's plan to address local housing needs. Grantees partner with nonprofit organizations and housing agencies to provide housing and support to beneficiaries. Persons who have HIV or AIDS and whose incomes are at or below 80% of the Area Median Income, which varies from state to state, are eligible for HOPWA housing.

How are HOPWA Funds Distributed?

HOPWA distributes program funds using a formula based on the number of AIDS cases in a given area. Three-quarters of HOPWA formula funding is awarded to qualified state and metropolitan areas with the highest number of AIDS cases. One-quarter of the formula funding is awarded to metropolitan areas that have a higher-than-average number of AIDS cases.

Competitive Grants Each year, HUD makes approximately 10 percent of the HOPWA grant funds available for competitive grant awards. This is done through a national competition to select model projects or programs. HUD outlines funding availability through an annual Notice of Funding Availability (NOFA) that lists available funds and provides instructions on how to apply for them. Nonprofit organizations and states, cities, and local governments may apply for HOPWA Competitive Program grants directly through HUD's NOFA process, or through their state, city, or local government.

Technical Assistance HOPWA National Technical Assistance awards are part of a separate competition under the Community Development Technical Assistance section of the HUD NOFA. Awards are provided to strengthen the management, operation, and capacity of HOPWA grantees. Nonprofit organizations, states, and units of local government that do not qualify for HOPWA Formula Program grants may apply for HOPWA Technical Assistance awards.

Centers for Medicaid and Medicare Services (CMS)

The Centers for Medicare and Medicaid Services (CMS, www.cms.hhs.gov) is the federal agency that administers Medicare and the federal parts of the Medicaid program. CMS has resources for HIV positive individuals that explain the eligibility requirements for Medicare, and that can walk them through their state's Medicaid eligibility requirements. It is important for your organization to be familiar with CMS' resources, Medicare benefits related to HIV, as well as your state's Medicaid benefits for people living with HIV and AIDS.

Some HIV positive individuals qualify for both Medicare and Medicaid. CMS can help individuals determine which programs they qualify for and how they can access both programs' services. One CMS service that may be critical for Medicare eligible, HIV positive individuals is Medicare prescription drug coverage. Established in January 2006, the Medicare prescription drug benefit can help those who are HIV positive pay for their medications. In fact, all Medicare drug plans cover antiretroviral medications. Through its Web site, CMS offers a publication, Your Guide to Medicare Prescription Drug Coverage, which describes the program, eligibility requirements, and the steps people can take to enroll (www.medicare.gov/publications/pubs/pdf/11109.pdf).

As a state administered entitlement, Medicaid benefits for HIV positive individuals differ by state and must be confirmed through the state Medicaid agency. The CMS Web site provides a general overview of Medicaid and the range of health services potentially covered by Medicaid programs.

WHAT HOPWA SERVICES CAN I PROVIDE?

Housing information services, including housing counseling, housing advocacy, fair housing information, and housing search and assistance

Resource identification to develop housing assistance resources, outreach, and relationship building with landlords

Acquisition, rehabilitation, conversion, lease, and repair of facilities to provide housing and services

New construction for Single Room Occupancy (SRO) and community residences

Project or tenant-based rental assistance, including shared housing arrangements, transitional, and permanent housing

Short-term rent, mortgage, and utility assistance to prevent homelessness

Supportive services, including health, mental health, case management, and day care

Resources for Your Work: Applying for Funding

An Introduction to Federal, State and Local Funding for HIV/AIDS

When you are ready to apply for federal, state, or local funding, there are certain steps your organization can take to manage your efforts and stay abreast of funding opportunities. In general, there are two ways that community-based organizations access federal funds: 1) directly from a federal agency, like CDC, SAMHSA, or HRSA, or 2) applying to state or local government as a sub-recipient.

Applying to the Federal Government

Step 1 If you are applying for direct federal funds, you will need to register your organization with www.grants.gov. The full registration process may take a couple of weeks, so do this early. Also, be prepared to download software from the Web site that will allow you to submit your application.

Step 2 Determine if the funding application you are responding to requires a Letter of Intent. This letter is from your organization to the funding agency and states your intent to apply for funding in response to the funding announcement.

Step 3 Complete the Standard Forms created by the OMB to apply for federal grants. Note: the forms are submitted as a part of your application package. The Standard Forms will be inserted in the application package that you get from www.grants.gov.

Step 4 In addition to the Standard Forms, there are eight basic components to creating an application: 1) the proposal summary; 2) introduction of organization; 3) the problem statement (or needs assessment); 4) project objectives; 5) project methods or design; 6) project evaluation; 7) future or committed funding, including long-range plans for keeping your project going; and 8) the project budget and a project justification (rationale).

Step 5 Your application will generally go through two levels of review. This process is called an objective review and ensures that the process is fair for all applicants. First, there is an initial screening to see if your application follows basic requirements for submission (like number of pages). Once this is done, your application will be reviewed by a panel using the evaluation criteria outlined in the funding announcement. The panel will provide recommendations and the agency is responsible for making the final decision about your application.

Applying to your State or Local Government

Federal programs allocate funding to states based on the needs of communities affected by HIV/AIDS within each state. State governments in turn award that money to county or city level entities to deliver HIV/AIDS services.

HIV/AIDS funding to your state or local government may come from these major federal programs:

Discretionary HIV/AIDS Federal Assistance

- Ryan White HIV/AIDS Treatment Modernization Program
- AIDS Drug Assistance Program (ADAP)
- Housing Opportunities for Persons with AIDS
- Minority HIV/AIDS Initiative

Entitlement Programs

- Medicaid
- Medicare
- Social Security Disability Insurance (SSDI)
- Supplemental Security Income (SSI)

Community and faith-based organizations like yours receive federal funding primarily as sub-recipients through county and city offices. This means that funds would be awarded by the city health department, for example, that has already received them directly from a federal agency, and is authorized to make them available to a sub-recipient such as your organization. You will have to compete with other organizations for those funds by responding to a Request for Applications issued by your state or local government.

Staying On Top of Funding Opportunities

As this guide has outlined, there are a number of opportunities for your organization to obtain financial assistance for HIV/AIDS work. Use the www.aids.gov Web site as a point of entry for all kinds of federally approved information on HIV/AIDS, including a description of HIV/AIDS activities by agency and what kind of funding may be available. Here are other steps you can take to stay on top of HIV/AIDS funding opportunities:

Review the Catalog for Federal Domestic Assistance (www.gsa.gov/fdac) to survey the types of HIV/AIDS programs for which federal funds are available.

Go to Grants.gov regularly to search for federal grant opportunities. If you find a grant or contract announcement and are interested in applying, each announcement will contain a link to download instructions and the forms you need. Go to www.grants.gov/applicants/applicant_faqs.jsp for more information.

Go directly to HHS (www.hhs.gov) for funding opportunities.

Visit CDC's National Prevention Information Network (www.cdcnpin.org) for updates on HIV/AIDS funding, as well as related news and resources.

Know your local funders, such as universities, foundations, local government, and local businesses. Develop relationships with these groups.

Review the Standard Government Forms for submitting a federal application, and forms for reporting, well in advance of your application deadline.

Have your attachments ready to go and be prepared to provide the following complete and up-to-date information for your application:

- ☐ Proof of your non-profit status
- ☐ Articles of incorporation and by-laws
- ☐ List of grants received (grantor, award amount and funding period)
- ☐ List of committed or potential funding sources, including partnership agreements
- ☐ Audit or CPA letter to confirm adequacy of your financial management system
- ☐ Documentation of cost share commitments
- ☐ Letters of support from partners and stakeholders
- ☐ Current list of Board of Directors including names, titles and addresses
- ☐ Resumes of project staff
- ☐ Strategic Plan that shows the need for the project you are proposing
- ☐ Information that identifies the specific project area, such as: Congressional District Number, census blocks and geographical boundaries.

Be responsive! It's possible for your application to be deemed non-responsive and disqualified if:

- ☐ The budget you propose exceeds the stated maximum amount of individual awards
- ☐ The application is missing required documents
- ☐ The page-length of the application exceeds the maximum allowed
- ☐ The application does not meet the deadline

Consider an HIV/AIDS program model that works. Many federal programs require that the use of best practices and nationally-recognized standards for delivery of services. Your application may be assessed in part on your ability to implement a best practice in HIV/AIDS. Models that have been proven effective already provide you with the best starting point for implementing a successful project. You can locate these best practice HIV/AIDS program models and standards at:

- ☐ HIV Prevention – www.cdc.gov/hiv/topics/research/prs/best-evidence-intervention.htm; www.cdcnpin.org
- ☐ HIV Care and Support Services – hab.hrsa.gov/publications.htm
- ☐ HIV-related Substance Use and Mental Health - www.samhsa.gov/ebpwebguide/index.asp

If your organization already receives funds directly from the Federal Government

If you are awarded funds from a federal agency like HRSA, CDC, or SAMHSA, it's likely that you had an application that was responsive to the needs of the federal program, and that you also demonstrated your capacity to implement the program. Here's what you should know:

- ☐ You will receive a grant award notification stating the duration of the award, the dollar amount, and a program contact. You also may receive a set of attachments that outline basic requirements that you must follow.
- ☐ You will be responsible for meeting the requirements as they appear in the OMB Circulars and Code of Federal Regulations. The applicable regulations will be clearly referenced in your Notice of Grant Award and terms of agreement.

You have to know the legal obligations that come along with a federal grant:

Financial reporting requirements. To make sure that grant funds are used properly, organizations that receive federal funds must file regular financial status reports. The basic financial report form is a one-page document called Standard Form 269. Many agencies have adapted this

form to suit their own programs. You can find a copy of Standard Form 269 at www.whitehouse.gov/omb/grants/grants_forms.html.

Cost-sharing/Matching. These are two terms that often are used interchangeably to describe your share or your organization's contribution of financial support to the funded program. Not all programs require a financial match. If a program does require a match, you will need to determine whether you can contribute the required level of funding and pledge to do so. A grantee's cost-share or match may be made in cash, in an in-kind contribution (such as facilities, equipment, and supplies), or in staff time.

Record-keeping. Your organization will be required to maintain financial and programmatic records for your project for up to three years following the project's end date. For some federal programs, it may be longer.

Performance Reporting. Typically, all grantees are required to submit both periodic and final performance reports that detail the project's accomplishments, as well as any problems or challenges. The awarding agency provides instructions for how to complete the report.

Audit. All organizations that receive federal funds are subject to basic audit requirements. The audits are necessary to make sure that federal dollars have been spent properly on legitimate costs. It is important for grant recipients to keep accurate records of all transactions conducted with federal funds. Most organizations are not audited by the government itself, although the federal government has the right to audit any program that receives public money at any time. For example, organizations that spend less than $500,000 a year in federal funds are generally asked to perform a "self-audit." For organizations that spend $500,000 or more in federal funds, an audit by an independent legal or accounting firm is required. Circular A-133 explains the Single Audit Act requirements for grantees receiving $500,000 or more in federal funds. More information on audits may be found on the Office of Management and Budget's Web site (www.whitehouse.gov/omb/circulars).

Conclusion

If you have read this guide cover-to-cover, you may feel overwhelmed by the intricate system of services, resources, and funding that comprise part of our national response to HIV and AIDS. Do not be intimidated, be empowered. Consider this guide as an instructive and supportive instrument that will help you and your community enter the fight against HIV and AIDS and be better prepared for this call to service. We expect you to liberally use this guide as a reference to explain the HIV/AIDS field, and increase your access to the resources, supports, and networks essential to helping you serve those in need.

Using this resource is the first step to meeting your goals in HIV/AIDS services. There is still much to learn and experience before you can effectively begin to plan, develop, and implement the high quality services you want to provide for your community. HIV/AIDS is a highly dynamic field that requires continual learning and reflection to meet people's needs. Those you serve deserve nothing less than the best, most informed services and programs to help them restore their lives, families, and communities.

Before you move forward with the many plans and ideas that came to you while reading the guide, remember to honestly take stock of yourself and your organization before starting on this journey. Take the time to really assess yourself and your team for readiness, then take the time to learn what is happening in your local community. Who are the players? What are the services? And more importantly, who are the clients and what are their needs? How do you ensure that you are working with people living with HIV/AIDS at every step? Then, ask yourself again whether you can offer clients the best possible solutions to their challenges, or if you are better suited to supporting those already working in the community to fight HIV/AIDS. Often the best work happens through reinventing or rebuilding an existing asset, not in creating a new one.

Community restoration can come in many forms. Whether your restoration effort comes by launching a new program to address unmet needs, or by contributing to those agencies needing additional support to improve community services, you are still both needed and welcome in this fight. However you decide to get involved, by learning more about HIV/AIDS and by considering your role in helping to transform and protect the lives in your community, you have taken a meaningful first step to beating this disease. If knowledge is the first brick in the wall of protection and transformation, restoration for you and your community has already begun.

Quick Links

AIDS.gov	www.aids.gov
CDC	www.cdc.gov
Preparing a CDC application	www.cdc.gov/about/business/funding.htm
CDC National Prevention Information Network	www.cdcnpin.org
CMS	www.cms.hhs.gov
Federal Grants Information	www.grants.gov
HHS	www.hhs.gov
HRSA HIV/AIDS Bureau	hab.hrsa.gov
HUD HOPWA Program	www.hud.gov/offices/cpd/aidshousing
Internal Revenue Service	www.irs.gov/charities
National Center for Secondary Education and Transition	www.ncset.org
National Minority AIDS Council	www.nmac.org
Office of HIV/AIDS Policy	www.hhs.gov/ophs/ohap
OMB	www.whitehouse.gov/omb
DUNS Number	www.whitehouse.gov/omb/grants/duns_num_guide.pdf
State Single Point of Contact Letter	www.whitehouse.gov/omb/grants/spoc.pdf
Standard Form 269	www.whitehouse.gov/omb/grants/grants_forms.html
Audit information	www.whitehouse.gov/omb/circulars
Ryan White HIV/AIDS Program	hab.hrsa.gov/about
Ryan White Part A Planning Council Primer	http://hab.hrsa.gov/tools/pcp08.htm
SAMHSA	www.samhsa.gov
Developing Competitive Grant Applications	www.samhsa.gov/grants/TA/index.aspx
Small Business Association	www.sba.gov
Small Business Planner	www.sba.gov/smallbusinessplanner

appendix

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appendix A

Key HIV/AIDS Data Sources

CDC HIV/AIDS Surveillance Reports	www.cdc.gov/hiv/topics/surveillance/resources/reports/index.htm
State-Level HIV/AIDS Data Tables (visit your local and state health department for more detailed data sets)	www.cdc.gov/hiv/topics/surveillance/resources/reports/tables.htm
United States Health Statistics and Trends 2007 (report published annually)	www.cdc.gov/nchs/data/hus/hus07.pdf
Healthy People 2010 Report and Database (federal health goals and benchmarks)	wonder.cdc.gov/data2010
National Center for Health Statistics	www.cdc.gov/nchs
National Behavior Risk Factor Surveillance System	www.cdc.gov/brfss
Youth Risk Behavior Surveillance System	www.cdc.gov/HealthyYouth/yrbs/index.htm
CDC National Prevention Information Network	www.cdcnpin.org
Drug Abuse Warning Network (DAWN)	dawninfo.samhsa.gov
Drug And Alcohol Services Information System (DASIS)	www.oas.samhsa.gov/dasis.htm
National Survey on Drug Use and Health (NSDUH)	www.oas.samhsa.gov/nsduh.htm
HRSA/HAB Program Data	hab.hrsa.gov/data
Providing HIV/AIDS Care	hab.hrsa.gov/provide
HRSA Grant Awards By Program and State	stateprofiles.hrsa.gov
HRSA Grantees by Program and State	granteefind.hrsa.gov
Statewide HOPWA Information	www.hud.gov/offices/cpd/aidshousing/local
Office of Women's Health Quick Health Data Online	www.healthstatus2010.com/owh

appendix B

Key Policies and Regulations

Finding and Applying for Government Grants www.grants.gov

The Federal Register www.gpoaccess.gov/fr

U.S. Department of HHS Grant Policy Statement www.hhs.gov/grantsnet/adminis/gpd/index.htm

U.S. Department of HHS Program Support Center Financial Management Service, Division of Payment Management Help Desk www.dpm.psc.gov/

CDC Grant Reference Information www.cdc.gov/od/pgo/funding/grants/references.shtm

SAMHSA Grants Management www.samhsa.gov/Grants/management.aspx

Peer Review Process Guidance www.cdc.gov/od/science/PHResearch/peerreview.htm

Government Travel Policy and Per Diem Rates www.gsa.gov/Portal/gsa/ep/ChannelView.do?PageTypeID=17113&channel Id=-24651

Health Insurance Portability and Accountability Act (HIPPA)

HIPPA Law: www.cms.hhs.gov/HIPAAGenInfo/Downloads/HIPAALaw.pdf

HIPPA FAQ: www.hhs.gov/hipaafaq/index.html

Administrative Simplification Compliance Act (1997 amendment to HIPPA) www.cms.hhs.gov/HIPAAGenInfo/Downloads/ASCALaw.pdf

National Standards to Protect the Privacy of Personal Health Information www.hhs.gov/ocr/hipaa

Security Information Series, a group of educational papers designed to give HIPAA covered entities insight into the Security Rule and assistance with implementation of the security standards. See the links below for pdf downloads of this series:

Security 101 www.cms.hhs.gov/EducationMaterials/Downloads/Security101forCoveredEntities.pdf

Administrative Safeguards www.cms.hhs.gov/EducationMaterials/Downloads/SecurityStandardsAdministrativeSafeguards.pdf

Physical Safeguards www.cms.hhs.gov/EducationMaterials/Downloads/SecurityStandardsPhysicalSafeguards.pdf

Basics of Risk Analysis and Risk Management www.cms.hhs.gov/EducationMaterials/Downloads/BasicsofRiskAnalysisandRiskManagement.pdf

Security Standards www.cms.hhs.gov/EducationMaterials/Downloads/SecurityStandardsOrganizationalPolicies.pdf

Security Standards Implementation for a Small Provider www.cms.hhs.gov/EducationMaterials/Downloads/SmallProvider4final.pdf

appendix C

Doing a Community Assessment

The following questions will assist you in performing a basic community assessment with community leaders and can be adapted and revised as needed:

Awareness, Resources, and Barriers

- ☐ Who is affected most by this disease?
- ☐ What are their races, ethnicities, and genders?
- ☐ What are their socio-economic levels?
- ☐ Where do they live?
- ☐ What other information do you have on this population?
- ☐ What is the impact of this disease in the community? For the individuals most affected? For their families?
- ☐ Are there barriers to addressing HIV/AIDS in the community (social, political, economic)? Can they be overcome and if so, how?
- ☐ What are the resources and strengths we have to address HIV/AIDS?
- ☐ How can we pool these resources and strengths and use them wisely?

Community Services, Attitudes, Beliefs, and Behaviors

- ☐ What has been done in the past to address HIV/AIDS in the community?
- ☐ What are the HIV/AIDS services available now in the community?
- ☐ Who was involved in HIV/AIDS work in the past, and who is involved now?
- ☐ If efforts already exist can those who are already involved be enlisted to help?
- ☐ Are the services being provided stable and sustainable for at least five more years?
- ☐ Which populations are not being served? Exactly what are the services that are not being provided to those who are underserved?
- ☐ What does the community know about HIV/AIDS?
- ☐ What are the myths and beliefs surrounding HIV/AIDS, if any?
- ☐ How can these perceptions be changed, if necessary?
- ☐ What are three major risk behaviors that you see being exhibited in the community, if any?
- ☐ Does the community see HIV/AIDS as an important issue?
- ☐ If not, what will make it important to different community groups?

appendix D

Community Mobilization

What is community mobilization?[2] Community mobilization engages all groups of people in a community-wide effort to address a health, social, or environmental issue. It brings together policy makers and opinion leaders, local, state, and federal governments, professional groups, religious groups, businesses, and individual community members. Community mobilization empowers individuals and groups to take some kind of action to facilitate change.

Part of the process includes mobilizing necessary resources, disseminating information, generating support, and fostering cooperation across public and private sectors in the community. Anyone can initiate a community mobilization effort — the HIV/AIDS division staff of local or state health departments, CBOs, or concerned physicians and other health professionals. All it takes is a person or a group to start the process and bring others into it in a participatory way.

Why mobilize the community?

- Infuse new energy into an issue through community buy-in and support
- Expand the base of community support for an issue or organization
- Help a community overcome stigma and denial of a health issue
- Promote local ownership and decision-making about a health issue
- Encourage collaboration between individuals and organizations
- Limit competition and duplication of services and outreach efforts
- Provide a focus for prevention planning and implementation efforts
- Create public presence and pressure to change laws, polices, and practices — progress that could not be made by just one individual or organization
- Bring new community volunteers together (because of increased visibility)
- Increase cross-sector collaboration and shared resources
- Increase access to funding opportunities for organizations and promote long-term, organizational commitment to social and health-related issues

Who will you need to mobilize in the community?

For community mobilization efforts addressing HIV/AIDS, it will be most effective to gather the support of those who have the most interaction and influence with the populations most at-risk for HIV/AIDS. They include:

- Clients and those already infected and affected by HIV
- Heath care providers
- Community Based Organizations (CBOs)
- Faith Based Organizations (FBOs)
- Local and state policy makers and opinion leaders (support from policy makers and opinion leaders can be achieved through efforts of CBOs and FBOs)
- Employers
- Schools

Mobilizing your community to address HIV/AIDS

Mobilizing your community to support efforts to address HIV/AIDS may seem very challenging, but if you break the effort into the following phases, you will be able to manage it in a focused and systematic way:

Phase I: Planning for Community Mobilization

Phase II: Raising Awareness

Phase III: Building a Coalition

Phase IV: Taking Action

Phase V: Monitoring and Evaluating

2 This appendix has been adapted from the CDC's "Community Mobilization Guide: A Community-Based Effort to Eliminate Syphilis in the United States". For more information, visit www.cdc.gov/std/see/Community/CommunityGuide.pdf

Phase I: Planning for Community Mobilization
Before you begin any HIV/AIDS work, you must undergo a planning phase to help determine the many factors that can influence your effort. Begin this phase by:

- Conducting a Community Assessment (See Appendix C for example)
- Involving the right people (clients, CBO and FBO leadership, community stakeholders, etc.)
- Selecting a strong leader
- Defining goals and strategies
- Developing ways to regularly measure progress
- Identifying funding and other resources

Action Steps You can begin planning your community assessment to identify critical issues and plan future interventions by:

- Interviewing and spending time with community members
- Conducting listening sessions and public forums
- Reading relevant government reports and other data sources
- Contacting the local, state, and other health departments in the region
- Identifying and working with community leaders and others involved in HIV/AIDS

Once your planning for community mobilization is complete, you are ready to move onto the next phases of Awareness Raising and Coalition/Partnership Building.

Phase II: Awareness Raising The community assessment will help guide you in determining the organizations and individuals you should contact and the best way to reach them. Begin this phase by:

- Preparing a community impact statement based on the HIV/AIDS problem in your community using the community assessment and other available information
- Making the community impact statement available in different formats (e.g., editorial, letter, press release)
- Determining the organizations, agencies, and individuals who should be involved in this effort and how you should get information to them
- Preparing the case for the issue (e.g., fact sheets, case histories) and making it relevant to your audience
- Developing an ongoing dialogue about the issue with those with whom you want to partner
- Approaching a wide spectrum of community leaders representing

  Private foundations

  State and local health coalitions

  Non-traditional community leaders from affected neighborhoods (e.g., convenience store owners, hairdressers, barbers, homeless shelter, and soup kitchen personnel)

  Policy makers

  Local media outlets

  School-based clinics

  Heath care providers

  Non-profit hospitals

  Heath insurance companies

  Correction facilities

  Sheriff 's office and police departments

  Drug treatment centers

  Community health centers

  African-American colleges and universities

  African-American fraternities and sororities

  Hispanic and other ethnic organizations

  Gay men's organizations

  Community activists

  Neighborhood associations

  AIDS service organizations (ASOs)

Action Steps

- Identify key messages to attract attention to the problem and its impact in your community. Create a list of appropriate organizations and representatives to target
- Develop background materials for interested parties, especially media

- Start to contact and brief those you would like to involve
- Send out letters and invitations
- Follow up with a phone call to get a sense of partners' interest

Phase III: Building a Coalition A community mobilizes when people become aware of a common need and decide together to take action to create shared benefits. Those concerned about the issue must create the momentum for mobilization — or it cannot be sustained over time. Once you decide to mobilize your community to conduct or expand HIV/AIDS service and prevention activities, you need to build your community coalition and partnerships. By building a community coalition that may have representation from health care providers, policy makers, and CBOs or FBOs leaders who serve, treat, and represent your target audience, you will build a unified voice and support for HIV/AIDS elimination efforts. Remember — there is strength in numbers. As you begin this phase, keep in mind the need to have the group develop a unified vision. A vision is a shared statement of what you want the initiative's success to look like. It unifies the different community segments that make up your community coalition. The coalition's goals, strategies, and activities will support this vision. The coalition's vision should reflect the findings of the community assessment.

Begin phase III by:

- Inviting all interested individuals to a planning meeting
- Using the responses to the letter and invitation as a starting point
- Identifying other community and professional networks that can be tapped and enlisted in HIV/AIDS elimination efforts.
- Preparing and training team members to become advocates for addressing HIV/AIDS

Action Steps

- Schedule the initial planning meeting
- Invite all interested individuals and groups that you have reached out to, including existing community and professional networks
- At the first meeting, determine your community coalition goals
- Brainstorm with the participants to identify other prospective stakeholders and community leaders and members you want to join the coalition
- Determine why they would support HIV/AIDS community mobilization efforts, how to best recruit them (use information from Phase II) and whether they have been involved in previous activities similar to this coalition
- Refer to your Community Assessment findings for insight
- Ensure your coalition is open and diverse and includes some "key players" that you know will take an active role
- Share with prospective members of the coalition a copy of the Community Assessment, community impact statement and any other appropriate documents prepared up to this point
- Develop a shared vision, mission statements, and feasible goals
- Establish your first few meetings and agendas

Phase IV: Taking Action With your community coalition in place and goals and vision established, you are ready to move into an action and outreach phase. As you develop and implement your action plan, keep in mind the importance of increasing the awareness and knowledge of your target audience and at-risk populations about HIV/AIDS. Refer to your Community Assessment Report and to the Vision and Mission Statements developed during earlier phases. The following is an outline of the key components of a strategic plan of action that can be adapted to your needs.

Strategic Plan of Action

Vision Statement: Your vision is your dream; it's the way you think things ought to be.

Mission Statement: What is going to be done and why.

Goals: Your goal(s) should have a specific outcome attached. You should have short-, mid-, and long-term goals.

Objectives: Specific measurable results of your work. A plan may have several objectives; however, each objective must support the broader goals.

Strategies: Broadly describe the paths you are going to take to achieve your objectives. There may be more than one strategy identified to help reach each objective. Each strategy must support the objectives.

Actions: Actions incorporate the specifics of what will be done, by whom, by when, and with what resources.

As you determine your actions, remember the following tips:

- You can have different actions to meet your different objectives and strategies
- Your actions may be very specific and be directed toward different target audiences such as policy makers, health care providers, STD clinic managers, community center directors, etc
- What do you want to change with your actions? A certain behavior, perception, or environmental norms?
- If people are going to make a behavior change, what changes in their environment need to occur to make that happen?
- Prioritize your actions. You may not be able to do everything at once due to limited financial and labor resources

Action Steps Evaluate the type of financial resources you have and the resources you need based on the information gathered in Phase I.

- Create a budget document to track these resources
- Identify resources by categories (e.g., grants, in-kind services, volunteers, etc.)
- Depending on the complexity of the budget, you may need coalition members to volunteer to serve as treasurer accountant and grant writer of the community mobilization effort
- Maintain the budget by categories to keep track of and ensure that projects can be completed with available resources
- Encourage partners to donate financial support and services

Prioritize activities based on funding that is available or will be available in the future

Phase V: Monitoring and Evaluating With any community mobilization effort, it is important to keep track of activities that are most effective in your community and those that may need to be improved upon to more successfully meet your goals.

Action Steps

- Determine the type of evaluation you plan to conduct and how you will collect data
- Develop both process (e.g., number of brochures distributed within a certain timeframe) and outcome (e.g., number of people who know about HIV/AIDS) measures
- Research and secure an evaluation contractor if needed
- Determine when in the timeline you are going to carry out monitoring and evaluation activities
- Develop evaluation plans and forms
- Keep coalition members involved in the evaluation activities, as their participation in the data collection and agreement on the follow-up actions are critical to the ongoing success of the coalition

appendix E

Sample Funding Announcement

This form must be signed by the project director and authorized business official.

b. You must also include documentation of approval by the relevant review panel of any HIV educational materials used by your project. Use the enclosed form Report of Approval. If you have nothing to submit, you must complete the enclosed form No Report Necessary. Either the Report of Approval or No Report Necessary must be included with all progress reports and continuation requests.

7. Address your organization's adherence to CDC policies for securing approval for CDC sponsorship of conferences. If you plan to hold a conference, you must send a copy of the agenda to CDC's Grants Management Office.

8. If you plan to use materials using CDC's name, send a copy of the proposed material to CDC's Grants Management Office for approval.

Note: Send all reports to the Grants Management Specialist identified in the Section VII. Agency Contacts section of this announcement.

VII. Agency Contacts

For general questions about this announcement, contact: Centers for Disease Control and Prevention, Technical Information Management Section (TIMS), Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341, Telephone: 770–488–2700.

For program technical assistance, contact: Samuel Taveras, Team Leader, Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of HIV/AIDS Prevention, 1600 Clifton Road, Mailstop E–40, Atlanta, GA 30333, Telephone: 404–639–5241, E-mail address: *dhapcbapt@cdc.gov.*

For budget assistance, contact: Carlos Smiley, Grants Officer, Centers for Disease Control and Prevention, Procurement and Grants Office, 2920 Brandywine Road, Room 3000, Atlanta, Georgia 30341–4146, Telephone: 770–488–2722, e-mail address: anx3@cdc.gov.

Dated: November 21, 2003.

Edward Schultz,

Acting Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 03–29806 Filed 11–26–03; 11:20 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Human Immunodeficiency Virus (HIV) Prevention Projects for Community-Based Organizations

Announcement Type: New.
Funding Opportunity Number: 04064.
Catalog of Federal Domestic Assistance Number: 93.939.

Key Dates

Letter of Intent Deadline: December 22, 2003.
Application Deadline: February 6, 2004.

I. Funding Opportunity Description

Authority: This program is authorized under sections 301(a) and 317(k)(2) of the Public Health Service Act, [42 U.S.C. 241 and 42 U.S.C. 247b(k)(2)], as amended.

Purpose: The purpose of the program announcement is consistent with CDC's Government Performance and Results Act (GPRA) performance plan and the CDC goal to reduce the number of new HIV infections in the United States. Funds are available under this announcement for HIV prevention projects for Community-Based Organizations (CBOs).

This program announcement addresses the "Healthy People 2010" focus area of HIV Prevention.

Measurable outcomes of this program will be in alignment with one (or more) of the following performance goal(s) for the National Center for HIV, STD and TB Prevention (NCHSTP):

- Decrease the number of persons at high risk for acquiring or transmitting HIV.
- Increase the proportion of HIV-infected people who know they are infected.
- Increase the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment services.
- Strengthen the capacity nationwide to monitor the epidemic, develop and implement effective HIV prevention interventions, and evaluate prevention programs.

The specific objectives of this announcement are to:

- Reduce HIV transmission.
- Increase the proportion of individuals at high risk for HIV infection who receive appropriate prevention services.
- Reduce barriers to early diagnosis of HIV infection.
- Increase the proportion of individuals at high risk for HIV infection who become aware of their serostatus.
- Increase access to quality HIV medical care and ongoing prevention services for individuals living with HIV.
- Address high priorities identified by the state or local HIV prevention Community Planning Group (CPG).
- Complement HIV prevention activities and interventions supported by state and local health departments.

Activities

Throughout this program announcement, you will be asked to adapt and tailor CDC procedures, including Replicating Effective Programs (REP) and Diffusion of Effective Behavioral Interventions (DEBI) (see Attachment I). This program announcement and all attachments for this announcement are located on the CDC Web site *http://www.cdc.gov.* To view CDC procedures, program announcement attachments and other available technical assistance visit *http://www2a.cdc.gov/hivpra/pa04064.html.* Definitions for terms used frequently throughout the program announcement can be found in the Program Announcement Glossary (see Attachment II). The terms defined below are used frequently throughout the program announcement and are also included in the Glossary.

For the purpose of this program announcement, an individual at high risk for HIV infection is someone who has had unprotected sex or has shared injecting equipment in a high-prevalence setting or with a person who is living with HIV.

A high-prevalence setting is a geographic location or community with an HIV seroprevalence greater than or equal to one percent.

An individual at very high risk for HIV infection is someone who (within the past six months) has:

- Had unprotected sex with a person who is living with HIV.
- Had unprotected sex in exchange for money or drugs.
- Had multiple (greater than five) or anonymous unprotected sex or needle-sharing partners.

OR

- Been diagnosed with a sexually transmitted disease (STD).

If CDC funds your CBO, you will be responsible for one or more of the following activities:

1. Conducting targeted outreach and providing Health Education/Risk Reduction (HE/RR) for high-risk individuals.

2. Conducting targeted outreach and providing Counseling, Testing, and

Referral (CTR) services for high-risk individuals.

3. Implementing one or more of the interventions below:

(a) Prevention for individuals living with HIV and their sex or injecting drug-using partners who are HIV negative or unaware of their HIV status.

(b) Prevention for individuals at very high risk for HIV infection.

(c) Partner Counseling and Referral Services (PCRS).

You must also:

4. Set a baseline level, annual targets, and five year overall target levels of performance for each core indicator identified by CDC (*see* Attachment III for a description of program performance indicators). If your CBO is funded, CDC will meet with you within 60 days to review the indicators. CDC will help you revise the indicators if necessary. If you fail to achieve your target levels of performance, CDC will work with you to improve performance. If your performance fails to improve, CDC may reduce the award or defund your program.

5. Collect monitoring and evaluation data and report required data to CDC's Program Evaluation and Monitoring System (PEMS) (*see* Attachment IV for a description of PEMS).

6. Refer individuals living with HIV to prevention services and medical care (including STD screening) if your CBO is unable to provide them directly.

7. Refer individuals at very high risk for HIV infection to prevention services if your CBO is unable to provide them directly.

8. Collaborate and participate in the HIV prevention community planning process with your local health department.

9. Identify and address the capacity-building needs of your program and participate in mandatory CDC-sponsored training.

In a cooperative agreement, CDC staff is substantially involved in program activities in addition to grant monitoring. If your CBO is funded under this announcement, CDC involvement will include:

1. Providing assistance and consultation on program and administrative issues directly or through partnerships with health departments, national and regional minority organizations, contractors, and other national and local organizations.

2. Working with you to assess your training needs and ensure that those needs are met.

3. Disseminating current information, including best practices, in all areas of HIV prevention.

4. Helping you to adopt effective intervention models through CDC procedures, workshops, conferences, and other written materials.

5. Providing assistance and information on new rapid HIV testing technologies.

6. Helping you establish partnerships with state and local health departments, community planning groups, and other groups who receive federal funding to support HIV/AIDS activities.

7. Ensuring that successful prevention interventions, program models, and lessons learned are shared between grantees through meetings, workshops, conferences, newsletter development, Internet, and other avenues of communication.

8. Monitoring your success in program and fiscal activities, protection of client privacy, and compliance with other organizational requirements.

9. Developing program evaluation guidelines and protocols and program monitoring systems (including indicators) and protocols.

10. Monitoring your progress toward achieving your target level of performance for each core indicator, and by working with you if you fail to achieve your target levels of performance.

11. Providing assistance with required program indicators.

II. Award Information

Type of Award: Cooperative Agreement.

Fiscal Year Funds: 2004.

Approximate Total Funding: $49,000,000.

CDC anticipates the following distribution of funds: $12 million for targeted outreach and health education/risk reduction; $14 million for targeted outreach and counseling, testing and referral services (CTR); and $23 million for prevention interventions.

Approximate Number of Awards: 160.

Approximate Average Award: $300,000.

Floor of Award Range: $100,000.

Ceiling of Award Range: $500,000.

Anticipated Award Date: June 1, 2004.

Budget Period Length: 12 months.

Project Period Length: Up to 5 years.

Continuation awards within an approved project period will be determined by the availability of funds and the best interest of the Federal Government. To be granted a continuation award, you must have:

- Completed all recipient requirements.
- Achieved your annual target levels of performance for each core indicator.
- Submitted all required reports.

III. Eligibility Information

Eligible Applicants

Applications may only be submitted by eligible CBOs, including faith-based CBOs. CBOs may apply under one of the following categories:

Category A: Providing HIV prevention services to members of racial/ethnic minority communities who are at high risk for HIV infection.

Category B: Providing HIV prevention services to members of groups at high risk for HIV infection regardless of their race/ethnicity.

Other Eligibility Requirements

To be eligible, your CBO must meet all criteria listed below. Your CBO must:

A. Have tax-exempt status.

B. Be located in the area(s) where services will be provided or have provided services in the area for at least three years.

C. Have discussed the details of your proposed CTR program with the health department and have agreed to follow their guidelines for these services if your CBO provides them (see Attachment V for a list of requirements).

D. Not be a government or municipal agency, private or public university or college, or private hospital.

E. Not be a 501(c) (4) organization.

Note: Title 2 of the United States Code section 1611 states that an organization described in section 501(c)(4) of the Internal Revenue Code that engages in lobbying activities is not eligible to receive federal funds constituting an award, grant, or loan.

F. If applying under Category A, your CBO must:

1. Have proof that 85 percent of the persons your CBO has served in each of the last three years were of racial/ethnic minority populations.

2. Have provided HIV prevention services in each of the last three years to your proposed high-risk population.

G. If applying under Category B, your CBO must:

1. Have proof that over 50 percent of the persons your program has served in each of the last three years were from high-risk groups, regardless of their race/ethnicity.

2. Have a program that has provided HIV prevention or care services in each of the last three years to your proposed target population, or have access to high-risk populations who do not have the services funded under this announcement available in their geographic area, such as transgender, drug-injecting women, and Native American populations.

Note: All information submitted with your application is subject to verification during pre-decisional site visits.

This program announcement is limited to CBOs due to their credibility among individuals living with HIV and those at very high risk for HIV infection. CBOs have proven their ability to access hard-to-reach populations (*e.g.*, Intravenous Drug Users) that have traditionally suffered exclusion from mainstream interventions and agencies.

Cost Sharing or Matching

Matching funds are not required for this program.

IV. Application and Submission Information

Letter of Intent (LOI)

Inform CDC that you plan to apply for funding by filling out the form found in Attachment VI. Please fax, mail, or e-mail your LOI to us by December 22, 2003. You may also complete this form online at: *http://www2a.cdc.gov/hivpra/pa04064.html.*

Although a letter of intent is not required, this information will assist CDC in planning for the review process.

Your LOI must contain:

- Your organization name, address, executive director.
- A description of your target population.
- A statement of your intent to apply and category under which you are eligible to apply (*e.g.*, Category A or Category B).

Your application should not accompany your LOI.

How to Obtain Application Forms: To apply for funding under this program announcement, use application form PHS 5161–1. Application forms and instructions are available on the CDC Web site, at the following Internet address: *http://www.cdc.gov/od/pgo/forminfo.htm.*

If you do not have access to the Internet, or if you have difficulty accessing the forms on-line, you may contact the CDC Procurement and Grants Office Technical Information Management Section (PGO–TIM) staff at 770–488–2700. Application forms can be mailed to you.

This program announcement provides final guidance on application format, content, and deadlines. If there are differences between the application form instructions and the program announcement, adhere to the guidance in the program announcement.

You are required to have a Dun and Bradstreet Data Universal Numbering System (DUNS) number to apply for a grant or cooperative agreement from the federal government. The DUNS number is a nine-digit identification number, which uniquely identifies business entities. Obtaining a DUNS number is easy and there is no charge. To obtain a DUNS number, access *http://www.dunandbradstreet.com* or call 1–866–705–5711.

For more information, visit the CDC Web site at: *http://www.cdc.gov/od/pgo/funding/pubcommt.htm.*

If your application form does not have a DUNS number field, please write your DUNS number at the top of the first page of your application, and/or include your DUNS number in your application cover letter.

Application Content and Form of Submission

You must submit a signed original and two copies of your application forms.

You must include a project narrative with your application forms. Your narrative should address the activities that that your CBO will conduct over the entire five-year project period.

Your narrative must be submitted in the following format:

There is a maximum limit of 40 single-spaced pages. If your narrative exceeds the page limit, only the first 40 pages will be reviewed.

- 12 point, unreduced font size.
- 8.5 by 11 inch paper.
- One-inch margins on each page.
- Printed only on one side of paper.
- Held together only by rubber bands or metal clips; not bound in any other way.

This section of the program announcement defines program requirements. You must describe your plans to address each requirement. Your application will be reviewed based on your answers to the questions in subsections A through I. Please answer each question with complete sentences and provide all requested documents. If you fail to provide the required documents, your application will not be considered for review.

This section also lists the core program indicators that will be used to measure your program's success. In your application, you are required to make an effort to report on the baseline level for each indicator, as well as projected one-year interim and five-year overall target levels of performance. When you apply for funding continuation, you will have the opportunity to revise your baseline, interim, and overall levels of performance, as specified in the guidance for completing your continuation application. In subsequent reports, you will report on the progress your CBO has made toward achieving your target level of performance for each core indicator.

When answering questions for subsections A-I, you must:

- Label your application using the subsection title and name of the subsection (*e.g.*, A. Eligibility) if applicable.
- Use the abbreviation N/A (not applicable), if a question or subsection does not apply to your application.

A. Eligibility

Suggested length: ten pages or less.

This section will not count toward the 40 page limit of your application, but it will determine if you are eligible for funding. Place all documents requested in subsection A in Appendix A, labeled Proof of Eligibility.

In your application, answer the following questions:

1. Are you applying under Category A: Providing HIV prevention services to members of racial/ethnic minority communities who are at high risk for HIV infection or Category B: Providing HIV prevention services to members of groups at high risk for HIV infection regardless of their race/ethnicity?

Note: For questions two through five, please provide documentation. Proof of location, history, and service must include at least one copy of a progress report describing services to the population served, a letter from one of your funding organizations, process monitoring data, service utilization data (which includes client characteristics), or a newspaper article.

2. Does your CBO have a valid Internal Revenue Service (IRS) 501(c)(3) tax-exempt status or state proof of incorporation as a non-profit organization? If you answer yes, you must attach a copy of the letter from the IRS or a copy of your state proof of incorporation. If you answer no, you are not eligible to apply for funding under this program announcement.

3. Are you located in the area in which services will be provided, or have you provided services in that area for at least three years?

4. If your CBO is applying under Category A:

(a) What proportion of the individuals your organization has served during each of last three years were members of racial/ethnic minority populations?

(b) What evidence do you have that your CBO has provided HIV prevention services in each of the last three years to your proposed high-risk population?

5. If your CBO is applying under Category B:

(a) What evidence do you have that your program has provided HIV prevention or care services to your proposed target population during each of the last three years, or has access to high-risk populations who do not have services available in the area?

(b) What proportion of individuals served by your program during the last three years were from high-risk groups?

6. Is your organization a governmental or municipal agency, a government-affiliated organization or agency (*e.g.*, health department, school board, public hospital), or a private or public university or college?

7. Is your organization included in the category described in section 501(c)(4) of the Internal Revenue Code of 1986 that engages in lobbying activities?

8. If you plan to offer HIV counseling and testing or partner counseling and referral services, have you discussed your proposed program with the health department? Have you agreed to follow the health department's guidelines for these services? Provide a letter from the health department addressing each item included in the sample letter. (Use Attachment VII).

9. Do you have voluntary counseling and testing, or care or treatment services, available onsite? If not, please provide a letter of intent to provide these services through another agency/agencies.

10. Is your organization applying as a single CBO, as a member of a coalition, or as a lead organization in a coalition, *e.g.*, a collaborative contractual partnership? Please indicate which.

11. Is your organization currently funded under CDC Program Announcement 99091, 99092, 99096, 00023, 00100, 01033, 01163 or 03003? Please indicate which announcement(s).

B. Justification of Need

Suggested length: five pages.

Note: Contact your health department to obtain HIV/AIDS statistics and HIV needs assessment data developed for the community planning process. This information will help you answer the questions in this section.

In your application, please answer the following questions:

1. What kind of services does your agency provide?

2. Which organizations provide similar services in your area?

3. Who is your proposed target population for this program announcement? Complete Attachment VIII and include it in your application as Appendix B.

4. What are the behaviors that place your target population at high risk for HIV infection or for transmitting the virus?

5. How has your proposed target population been affected by the HIV/AIDS epidemic? (*e.g.*, HIV incidence or prevalence, AIDS incidence or prevalence, AIDS mortality)

6. What history do you have serving this population? (Please explain how long you have provided services, describe what kinds of services have been provided, describe the outcomes of services you provided, and describe your relationship with the community.)

7. How do your staff members reflect your proposed target population? (Please describe, in aggregate, the characteristics of your key program staff in terms of experience working with the target population, gender, race/ethnicity, HIV serostatus, area of behavioral risk expertise, or other relevant factors.)

8. How will you involve the target population when planning and implementing your proposed services?

9. How will your proposed activities meet the needs of your target population or improve available services?

10. What services do you plan to provide under this program announcement? List all that apply in your application.

(a) Targeted outreach and HE/RR to high-risk individuals.

(b) Targeted outreach and CTR.

(c) Prevention interventions for individuals living with HIV and their sex or injection drug-using partners.

(d) Prevention interventions for individuals at very high risk for HIV infection.

(e) Partner counseling and referral services.

C. Targeted Outreach and Health Education/Risk Reduction for High-Risk Individuals

Suggested length: five pages.

1. If you are applying for targeted outreach and HE/RR services, you must conduct activities listed in sections F, G, H, and I. You must also:

(a) Using CDC procedures including REP and DEBI, (see Attachment I), implement targeted strategies to increase the number of high-risk individuals who reduce their risk for HIV infection and consent to testing. Your strategies should aim to reach high-risk individuals who have not tested in the last six months or do not know their HIV serostatus. Activities should be conducted in a setting that is comfortable and accessible to your clients. Your strategies should also improve access to other local HIV prevention services. The following strategies will be supported:

(1) Targeted outreach.

(2) Individual-level interventions.

(3) Small group-level interventions.

(4) Referral networks.

(b) Offer voluntary HIV counseling and testing to each individual identified through your program. If you do not conduct testing, you must establish a formal agreement with another agency/agencies to provide testing.

(c) Collect and report process and outcome monitoring data on the services you provide, including core performance indicators, as directed in the PEMS and the Evaluation Guidance.

2. In your application, please answer the following questions:

(a) How will you target your efforts to reach high-risk individuals who have not been tested in the last six months or do not know their HIV serostatus?

(b) How will you identify and address barriers to accessing your target population?

(c) How will you involve your target population when planning and implementing your proposed services?

(d) How will you ensure that your activities will reach individuals at high risk for HIV infection who are unaware of their HIV serostatus or are not receiving prevention or care services?

(e) How will you adapt and tailor relevant CDC procedures, including REP and DEBI, into your existing or proposed program?

(f) How will you ensure access to voluntary HIV counseling and testing services?

(g) What are your quality assurance strategies?

(h) How will you train, support, and retain staff to conduct interventions?

(i) How will you ensure client confidentiality?

(j) How will you ensure that your services are culturally sensitive and relevant?

(k) What are your baseline levels, projected one-year interim, and five-year overall target levels of performance for the following core program indicators?

(1) The mean number of outreach contacts required to get one person with unknown or negative serostatus to access counseling and testing.

(2) The proportion of persons who access counseling and testing from each of the following interventions: individual-level interventions and group-level interventions.

(3) Proportion of persons that completed the intended number of sessions for each of the following interventions: Individual-level interventions and group-level interventions.

D. Targeted Outreach and Counseling, Testing, and Referral Services (CTR)

Suggested length: seven pages.

1. If you are applying for targeted outreach and CTR, you must conduct activities listed in sections F, G, H and I. You must also:

(a) Use CDC procedures, including REP and DEBI, (*see* Attachment I) to provide counseling and voluntary HIV-testing services to high-risk individuals identified through your outreach strategies. CDC encourages recipients to use a Clinical Laboratory Improvement Amendments (CLIA) waived rapid test when appropriate and to process confirmatory tests at the state or local health department laboratory. (Research has shown that the use of rapid HIV tests increases the number of individuals who receive their results; and knowledge of HIV serostatus promotes safer behaviors.) Your proposed activities must meet all local, state, and federal requirements for HIV prevention counseling, testing, and referral services. If required by state regulations, provide a letter of intent from a physician stating his/her involvement in HIV-testing activities. This letter must address each item included in the sample letter (use Attachment VII).

Funding may be used to cover testing-related costs. You must share your plans with the health department and obtain a letter of support to be eligible for funding.

(b) Provide post-test prevention counseling services for persons whose HIV test results are negative, but who are at ongoing very high risk for HIV infection. You must also provide appropriate prevention interventions for this population. If you cannot provide these services directly, you must refer these individuals to appropriate prevention interventions. Contact your health department to identify available referral services in your area.

(c) Provide post-test counseling services for persons whose HIV test results are positive. You must refer these individuals to the health department for Partner Counseling and Referral Services (PCRS).

(d) Establish a formal agreement with a laboratory and provide a plan for ensuring training, oversight, quality assurance, and compliance with CLIA requirements and relevant state and local regulations applicable to waived testing, if you will be using a waived rapid HIV test. Obtain a CLIA Certificate of Waiver or approval to operate under that laboratory's CLIA certificate. Submit a letter of support from the laboratory. Include this document as Appendix C.

(e) Implement strategies to reduce your target population's barriers to accessing CTR services (*e.g.*, economic barriers, environmental barriers, cultural barriers, and social barriers).

(f) Collect and report counseling and testing data, including core performance indicators, as directed in the PEMS and the Evaluation Guidance, and follow required health department reporting procedures.

(g) Report confirmed HIV-positive tests to state and local health departments, following all rules and regulations regarding HIV and AIDS surveillance.

2. In your application, please answer the following questions:

(a) How will you ensure that counseling and testing activities will reach high-risk individuals who have not tested in the last six months or do not know their HIV serostatus?

(b) How will you identify and address your target population's barriers to accessing voluntary HIV counseling and testing services?

(c) How will you ensure that clients receive their test results, particularly clients who test positive?

(d) How will you ensure that individuals with initial HIV-positive test results will receive confirmatory tests? (If you do not provide confirmatory HIV testing, you must provide a letter of intent or memorandum of agreement with an external laboratory documenting the process through which initial HIV-positive test results will be confirmed.)

(e) How will you involve the target population when planning and implementing your proposed services?

(f) How will you adapt, tailor, and implement relevant CDC procedures, including REP and DEBI?

(g) What are your quality assurance strategies?

(h) How will you train, support, and retain staff providing counseling and testing?

(i) How will you ensure client confidentiality?

(j) How will you ensure that your services are culturally sensitive and relevant?

(k) What are your baseline levels and projected one-year interim and five-year overall target levels of performance for the following core program indicators?

(1) Percent of newly identified, confirmed HIV-positive test results among all tests funded by CDC and reported by your organization.

(2) Percent of newly identified, confirmed HIV-positive test results delivered to clients.

E. Prevention Interventions

Suggested length: seven pages.

1. If you are applying for funding to provide prevention services, you must conduct activities listed in sections F, G, H, and I. You must also:

(a) Implement one or more of the interventions below using standard CDC procedures; including REP and DEBI (*see* Attachment I):

(1) Prevention interventions for individuals living with HIV, and their sex and injection drug-using partners who are HIV negative or are unaware of their HIV serostatus.

(2) Prevention interventions for seronegative individuals at very high risk for HIV infection.

(3) Partner Counseling and Referral Services (PCRS).

(b) If you want to provide PCRS, you must work with your health department and meet all local, state, and federal requirements for providing these services. Obtain a letter of agreement from your health department which must also state that your CBO meets all local, state, and federal requirements. This letter must address each item included in the sample letter. (Use Attachment VII.)

(c) Collect and report process and monitoring data on these services, including core performance indicators, as directed in the PEMS and Evaluation Guidance.

2. In your application, for each service you plan to provide, please answer the following questions:

(a) What are your proposed prevention interventions?

(b) How will you identify and offer services to individuals living with HIV, and their sex and injection drug-using partners who are HIV negative or who do not know their HIV status?

(c) How will you identify and offer services to individuals at very high risk for HIV infection?

(d) Where will you provide prevention services? (Please describe the setting.)

(e) How will you maintain and retain individuals in your prevention intervention(s)?

(f) How will you coordinate prevention services with other case management and/or treatment providers for individuals living with HIV?

(g) How will you ensure that prevention services do not duplicate services provided by the Ryan White Care Act program?

(h) How will you address barriers related to partner counseling and referral services?

(i) What are the qualifications of staff providing prevention services?

(j) How will you involve the target population when planning and implementing your proposed services?

(k) How will you adapt, tailor, and implement relevant CDC procedures, including REP and DEBI?

(l) What are your quality assurance strategies?

(m) How will you train, support, and retain staff to provide these interventions?

(n) How will you ensure services are culturally sensitive and relevant?

(o) How will you ensure client confidentiality?

(p) What are your baseline levels, projected one-year interim, and five-year target levels of performance for the following core program indicators relevant to your program:

(1) Proportion of persons living with HIV and their sex and injection drug-using partners who are HIV negative or who do not know their HIV status that completed the intended number of sessions for each of the prevention interventions supported by this program announcement.

(2) Proportion of persons at very high risk for HIV infection who completed the intended number of sessions for each of the prevention interventions supported by this program announcement.

(3) Percent of HIV infected persons who, after a specified period of participation in each of the prevention interventions supported by the program announcement, report a reduction in sexual or drug-using risk behaviors or maintain protective behaviors with seronegative partners or with partners of unknown status.

(4) Percent of contacts with unknown or negative serostatus receiving an HIV test after PCRS notification.

(5) Percent of contacts with a newly identified, confirmed HIV-positive test among contacts who are tested.

(6) Percent of contacts with a known, confirmed HIV-positive test among all contacts.

F. Evaluation and Monitoring Intervention Activities

Suggested length: five pages.

1. You must:

(a) Collect and report client-level data.

(b) Collect and report standardized process and outcome monitoring data consistent with CDC requirements.

(c) Enter and transmit data for CDC-funded services on CDC's browser-based system or describe plans to make a local system compatible with CDC's system. (There is a description of PEMS in Attachment IV.)

(d) Collect and report data consistent with CDC requirements to ensure data quality and security and client confidentiality.

(e) Collaborate with CDC to assess the impact of HIV prevention activities and participate in special projects upon request.

2. In your application, please describe your:

(a) Current system of data collection and methods for reporting HIV prevention activities including data system specifications and data management information systems.

(b) Capacity to collect and report client-level data for HIV prevention services and the effect of those services on client HIV risks and health service utilization.

(c) Plans to identify and address barriers and facilitators to the collection of client-level demographic and behavioral characteristics.

(d) Plans to ensure that data quality and security are consistent with CDC requirements and guidelines.

(e) Willingness to collaborate with CDC in the design and implementation of other evaluation projects.

(f) Technical assistance needs to meet evaluation and monitoring requirements.

(g) Baseline level, one-year interim, and five-year overall target levels of performance for the following core indicator: proportion of client records with the CDC-required demographic and behavioral risk information.

G. Referral Activities

Suggested length: four pages.

1. For services not available through your organization, you must:

(a) Collaborate with other agencies to increase the number of persons who receive comprehensive services including prevention, testing, medical care, mental health, and drug abuse treatment.

(b) Develop a formal agreement such as a memorandum of understanding with each collaborating agency serving persons identified through your program within six months of funding.

(c) Track referral activities and their outcomes. You must document the type of referral (*e.g.* mental health, housing), date of referral, and outcome of referral (such as completion of first appointment).

(d) Collect and report data on referrals, including core performance indicators, as directed in the PEMS and Evaluation Guidance.

2. In your application, you must:

(a) Describe your plans to develop a referral network to ensure that clients identified through your program have access to comprehensive services including access to primary care, life-prolonging medications, and essential support services that will maintain HIV-positive individuals in systems of care.

(b) Provide documentation of any formal agreements with providers and other agencies where your clients may be referred.

(c) Specify baseline levels, projected one-year interim, and five-year overall performance levels for the following core indicator: The mean number of outreach contacts required to get a person living with HIV, and their sex and injection drug-using partners, or an individual at very high risk for HIV infection, to access referrals made under this program announcement.

H. Collaboration and Coordination With the HIV Prevention Community Planning Process and Local Health Department

Suggested length: three pages.

1. You must:

(a) Collaborate and coordinate activities with the HIV prevention CPG and local health department. Collaboration activities may include participating in the needs assessment process, reviewing and commenting on plans, presenting an overview of your project activities to the CPG in their jurisdiction and making clients available for focus groups and other planning activities. Coordination activities may include sharing progress reports, program plans, and monthly calendars with state and local health departments, CPGs, and other organizations and agencies involved in HIV prevention activities serving your target population.

(b) Participate in the HIV prevention community planning process. Participation may include involvement in workshops, attending meetings, serving as a member of the CPG, and becoming familiar with and utilizing information from the community planning process, such as the epidemiologic profile, needs assessment data, and intervention strategies. Membership in the CPG is not required, and it is determined by the group's bylaws and selection criteria.

2. In your application, describe your plans to:

(a) Participate, collaborate, and coordinate with the HIV prevention CPG.

(b) Participate, collaborate, and coordinate with the local health department.

(c) Participate in the HIV prevention community planning process.

I. Capacity Building

Suggested length: four pages.

1. You must:

(a) Conduct a capacity-building needs assessment.

(b) Develop a comprehensive capacity-building plan based on the outcomes of the needs assessment.

(c) Share any new CBA needs that develop during the project period with your project officer.

(d) Attend a grantee orientation for administrative and programmatic staff.

(e) Participate in any mandatory training conducted or sponsored by CDC.

(f) Ensure that your CBO's financial manager attends a CDC-sponsored financial training. If the financial manager leaves your agency, his/her replacement must attend training within six months.

2. In your application, please answer the following questions:

(a) What are your immediate, intermediate and long term CBA needs; and how do you plan to address them?

(b) How do you plan to share any new CBA needs that develop during the project period with your project officer?

J. Guidance on Use of Funds

You must consider the following funding restrictions when you are creating your project budget:

- Funds may be used to hire contractors or support coalition partners to strengthen program activities. CDC encourages you to develop coalitions with other prevention providers, medical providers, and health departments to implement your proposed program; however, your CBO, not the contract organization(s) or the coalition partner(s), must conduct the largest portion of the activities (including managing the program and activities) funded by this award.
- Funds cannot be used to provide medical or substance abuse treatment.

If you are requesting indirect costs in your budget, you must include a copy of your negotiated indirect cost rate agreement. If your indirect cost rate is a provisional rate, the agreement must be less than 12 months of age.

For budget guidance, visit the CDC Web site *http://www.cdc.gov/od/pgo/funding/budgetguide.htm.*

Submission Date, Time, and Address

LOI Deadline Date: December 22, 2003.

LOI Submission Address: Submit your LOI by express delivery service, or e-mail to: William Bancroft, Public Health Analyst, CDC, NCHSTP, DHAP, IR, 1600 Clifton Road, MS E58, Atlanta, GA 30333, *Pa04064@cdc.gov.*

Application Deadline Date: February 6, 2004.

Application Submission Address: Submit your application by mail or express delivery service to: Technical Information Management—PA# 04064, CDC Procurement and Grants Office, 2920 Brandywine Road, Atlanta, GA 30341.

Explanation of Deadlines: Applications must be received in the CDC Procurement and Grants Office by 4 p.m. Eastern Time on the deadline date. If you send your application by the United States Postal Service or commercial delivery service, you must ensure that the carrier will be able to guarantee delivery of the application by the closing date and time. If CDC receives your application after closing due to: (1) carrier error, when the carrier accepted the package with a guarantee for delivery by the closing date and time, or (2) significant weather delays or natural disasters, you will be given the opportunity to submit documentation of the carrier's guarantee. If the documentation verifies a carrier problem, CDC will consider the application as having been received by the deadline.

If your application does not meet the submission deadline, it will not be eligible for review and will be discarded. You will be notified that you did not meet the submission requirements.

CDC will not be sending postcards to confirm application receipt. Please contact your mail carrier to confirm delivery. If you still have questions, contact the PGO–TIM staff at 770–488–2700. Before calling, please wait two to three days after the application deadline. This will allow time for the applications to be processed and logged.

Intergovernmental Review of Applications: Executive Order 12372 does apply to this program.

V. Application Review Information

Review Criteria: You are required to provide measures of effectiveness that will demonstrate the accomplishment of the various identified objectives of the cooperative agreement. Measures of effectiveness must relate to the performance goals stated in the "Purpose" section of this announcement. Measures must be objective and quantitative, and must measure the intended outcome. These measures of effectiveness must be submitted with the application and will be an element of evaluation.

There are 2 steps to the evaluation process.

Step One

In the first step of the evaluation process, your application will be evaluated based on each item referenced in Section IV., entitled, "Application and Submission Information." Your application will be evaluated by an independent review panel assigned by CDC. The panel will assign your application a score using scored evaluation criteria as specified in Section V., entitled, "Application Review Information," and based on your responses to the questions in Section IV., entitled, "Application and Submission Information" beginning with B. Justification of Need. Your application will be ranked based on this score. The highest-ranked applications will be considered for a pre-decisional site visit (Step two).

Step Two

The second step of the review process is conducted via pre-decisional site visits which are worth 100 points. To be considered for funding, you must score at least 70 points during this process. If you fail to reach 70 points, your CBO will be disqualified. CDC will invite health department staff to participate in the site visit.

Criteria for Step One: Application Review

Your application will be evaluated on the following criteria:

A. Eligibility (not scored)

This section of your application will be reviewed to determine if you are eligible for funding.

B. Justification of Need (200 points)

This section of your application will be scored based on your description of:

- The target population's needs.
- How your proposed intervention meets the needs of the jurisdiction's HIV Prevention Comprehensive Plan.
- Your experience and credibility in working with the proposed target population.

C. Targeted Outreach and Health Education/Risk Reduction for High-Risk Individuals (150 points)

This section of your application will be scored based on your target levels of performance for each core indicator and your plans to:

- Increase the number of persons at high risk for HIV infection who learn their HIV serostatus.
- Identify persons at high risk for HIV infection.
- Identify and address your target population's barriers to accessing HE/RR.
- Involve the target population when planning and implementing your program(s).
- Adapt and tailor CDC procedures, including REP and DEBI.
- Offer voluntary HIV counseling and testing to each individual reached by your program.
- Ensure that individuals who consent to HIV testing receive a test either through your CBO or via referral.
- Develop, implement, and maintain quality assurance strategies.
- Train, support, and retain staff.

- Ensure client confidentiality.
- Ensure cultural sensitivity and relevance of your interventions.

D. Targeted Outreach and Counseling, Testing, and Referral Services (CTR) (150 points)

This section of your application will be scored based on your target levels of performance for each core indicator and your plans to:

- Identify high-risk individuals who have not tested within the past six months or do not know their HIV serostatus for voluntary counseling and testing.
- Identify and address your target population's barriers to accessing counseling and testing services.
- Ensure clients receive their test results.
- Ensure confirmatory testing for positive initial test results.
- Involve your target population when planning and implementing your program(s).
- Adapt and tailor CDC procedures, including REP and DEBI, to your existing or proposed services.
- Develop, implement, and maintain quality assurance strategies for counseling, testing, and referral services.
- Train, support, and retain staff.
- Ensure client confidentiality.
- Ensure cultural sensitivity and relevance of your interventions.

E. Prevention Interventions (175 points)

This section of your application will be scored based on your proposed target levels of performance for each core indicator and your plans to:

- Identify and offer services to individuals living with HIV, and their sex and injection drug-using partners who are HIV negative, or who do not know their HIV status.
- Identify and offer services to individuals at very high risk for HIV infection.
- Coordinate prevention services with other case management and/or treatment providers for individuals living with HIV.
- Ensure that prevention services do not duplicate services provided by the Ryan White Care Act program.
- Identify and address barriers to retaining persons in interventions.
- Identify and address barriers to conducting your proposed prevention interventions.
- Meet all local, State, and Federal requirements for HIV prevention services.
- Involve your target population when planning and implementing your program(s).
- Adapt and tailor relevant CDC procedures, including REP and DEBI, to your existing services or proposed program.
- Develop, implement, and maintain quality assurance strategies for prevention interventions.
- Train, support, and retain staff.
- Ensure client confidentiality.
- Ensure cultural sensitivity and relevance of the prevention interventions.

F. Evaluation and Monitoring Intervention Activities (100 points)

This section of your application will be scored based on your target levels of performance for each core indicator and the description of your:

- Current data collection and reporting systems.
- Capacity to collect and report client-level data.
- Plans to identify and address barriers to client-level data.
- Plans to ensure data quality and security.
- Willingness to collaborate with CDC in special evaluation and monitoring projects.
- Technical assistance needs to meet evaluation and monitoring requirements.

G. Referral Activities (100 points)

This section of your application will be scored based on your baseline and projected target levels of performance for each core indicator and your plans to:

- Identify and collaborate with other agencies to ensure access to comprehensive services, including access to primary care, life-prolonging medications, and essential support services that will maintain HIV-positive individuals in systems of care.
- Track referral activities and outcomes of these activities.
- Develop formal agreements with your network of providers.

H. Collaboration and Coordination With the HIV Prevention Community Planning Process and Local Health Department (75 Points)

This section of your application will be scored based on your plans to:

- Collaborate and coordinate activities with the HIV prevention Community Planning Group (CPG).
- Collaborate and coordinate activities with the health department.
- Participate in the HIV prevention community planning process.

I. Capacity Building (50 points)

This section of your application will be scored based on your plans to:

- Conduct a comprehensive capacity-building needs assessment of your agency.
- Work with CDC-coordinated capacity-building programs.

Step Two: Pre-Decisional Site Visit

The following areas will be evaluated during the visit:

A. Proposed Program (250 points)

The purpose of this section is to assess your CBO's ability to effectively implement your proposed HIV prevention interventions. Your score will be based on:

- Your implementation of CDC protocols and procedures, including REP and DEBI.
- Your one-year and five-year overall target levels of performance
- How your target population reflects the priorities identified in the HIV Prevention Comprehensive Plan.
- How your interventions reflect the needs identified in the your jurisdiction's HIV Prevention Comprehensive Plan.

B. Programmatic Infrastructure (200 points)

The purpose of this section is to assess your CBO's experience and ability to identify and address the needs of your proposed target population. This section will also assess your ability to effectively and efficiently implement your proposed activities. Your score will be based on your CBO's:

- Organizational structure and planned collaborations.
- Experience in developing and implementing effective and efficient HIV prevention strategies and activities.
- Experience with governmental and non-governmental organizations, including other national agencies or organizations, state and local health departments, CPGs, and state and local non-governmental organizations that provide HIV prevention services.
- Ability to secure meaningful input and representation from members of the target population(s).
- Ability to provide culturally competent and appropriate services that respond effectively to the characteristics of the target population (characteristics may include cultural, gender, sexual orientation, HIV serostatus, race/ethnicity, age, environmental, social, and linguistic characteristics).
- Ability to adequately staff your program.
- Ability to collect and report process and monitoring data on services provided and use them to plan future interventions and improve available services.

C. Organizational Infrastructure (150 points)

The purpose of this section is to assess your CBO's ability to effectively and efficiently sustain your proposed program. Your score will be based on your CBO's:

- Organizational bylaws, mission, and vision.
- Composition, role, experience, and involvement of the board of directors in administering the agency.
- Current fiscal systems to track available funding.
- Personnel process and procedures.
- Organizational protocols and procedures *e.g.*, security, confidentiality, and grievances.
- Organizational capacity for fundraising.

D. Health Department Review (100 points)

The purpose of this section is to gather feedback on your proposed program plan from the health department. Your score will be based on the health department's review of your:

- Review of the program plan (e.g., proposed target population, proposed intervention(s), number of persons to be served, and service location) and your consistency with the HIV Prevention Comprehensive Plan.
- Rating of past experience with state/city-funded programs.
- Letter of support or non-support for funding from the health department, addressed to CDC.

CDC's Procurement and Grants Office (PGO) will conduct a Recipient Capability Assessment (RCA) to evaluate your CBO's ability to manage CDC funds. This assessment will be conducted by either PGO staff or another selected agency.

Review and Selection Process

In addition to your application content score and the outcome of your pre-decisional site visit, the following factors may affect the funding decision: Preference for funding will be given to ensure that:

- Funded CBOs are balanced in terms of targeted racial/ethnic minority groups. (The number of funded CBOs serving each racial/ethnic minority group may be adjusted based on the burden of infection in that group as measured by HIV or AIDS reporting.)
- Funded CBOs are balanced in terms of targeted risk behaviors. (The number of funded CBOs serving each risk group may be adjusted based on the burden of infection in that group as measured by HIV or AIDS reporting.)
- Funded CBOs are balanced in terms of geographic distribution. (Consideration will be given to both high and lower prevalence areas; the number of funded CBOs may be adjusted based on the burden of infection in the jurisdiction as measured by HIV or AIDS reporting.)
- Funded CBOs are balanced in terms of targeted gender. (The number of funded CBOs serving each gender group may be adjusted based on burden of infection in that group as measured by HIV or AIDS reporting.)
- Funding opportunities are available for faith-based CBOs and CBOs serving rural areas, incarcerated individuals, or high risk populations who do not have the services funded under this announcement available in their geographic area.

VI. Award Administration Information

Award Notices: If your CBO is funded, you will receive a Notice of Grant Award (NGA) from the CDC Procurement and Grants Office. The NGA shall be the only binding, authorizing document between the recipient and CDC. The NGA will be signed by an authorized Grants Management Officer, and mailed to the recipient fiscal officer identified in the application.

Administrative and National Policy Requirements: 45 CFR part 74 and 92.

For more information on the Code of Federal Regulations, see the National Archives and Records Administration at the following Internet address: *http://www.access.gpo.gov/nara/cfr-table-search.html.*

The following additional requirements apply to this project:

- AR–4 HIV/AIDS Confidentiality Provisions
- AR–5 HIV Program Review Panel Requirements
- AR–7 Executive Order 12372
- AR–8 Public Health System Reporting Requirements
- AR–9 Paperwork Reduction Act Requirements
- AR–10 Smoke-Free Workplace Requirements
- AR–11 Healthy People 2010
- AR–12 Lobbying Restrictions
- AR–14 Accounting System Requirements
- AR–15 Proof of Non-Profit Status

Additional information on these requirements can be found on the CDC Web site at the following Internet address: *http://www.cdc.gov/od/pgo/funding/ARs.htm.*

Reporting Requirements

1. You must provide CDC with an original, plus two copies of the following reports:

(a) Your interim progress report, no later than February 15 of each year. The progress report will serve as your non-competing continuation application, and must contain the following elements:

(1) Current budget period activities objectives.

(2) Current budget period financial progress.

(3) New budget period proposed program activity objectives.

(4) Detailed line-item budget and justification.

(5) Baselines and target levels of performance for core and optional indicators.

(6) New budget period proposed program activities.

(7) Additional requested information.

(b) The second semi-annual report will be due August 30 of each year. Additional guidance on what to include in this report may be provided approximately three months before the due date. It should include:

(1) Baseline and actual level of performance on core and optional indicators.

(2) Current budget period financial progress.

(3) Additional requested information.

(c) Financial status report, no more than 90 days after the end of the budget period.

(d) Final financial and performance reports, no more than 90 days after the end of the project period.

(e) Data reports of agency, financial, and HIV interventions including, but not limited to, HIV individual and group level; PCM; outreach; CTR; and/or partner CTR services are required 45 days after the end of each quarter or as specified in the most recent evaluation guidance. Project areas may request technical assistance. Submit data to the Program Evaluation Research Branch electronically, and then send an electronic notification of your data submission to the Grants Management Specialist listed in the "Agency Contacts" section of this announcement.

2. Submit any newly developed public information resources and materials to the CDC National Prevention Information Network (formerly the AIDS Information Clearinghouse) so that they can be incorporated into the current database for access by other organizations and agencies.

3. HIV Content Review Guidelines. (a) Submit the completed Assurance of Compliance with the Requirements for Contents of AIDS-Related Written Materials Form (CDC form—0.1113) with your application as Appendix D. This form lists the members of your program review panel. The form is included in your application kit. The

current Guidelines and the form may be downloaded from the CDC Web site: *http://www.cdc.gov/od/pgo/forminfo.htm*. Please include this completed form with your application. This form must be signed by the Project Director and authorized business officer.

(b) You must also include approval by the relevant review panel of any CDC-funded HIV educational materials that you are currently using by the relevant review panel. Use the enclosed form, "Report of Approval". If you have nothing to submit, you must complete the enclosed form "No Report Necessary". You must include either the "Report of Approval" or "No Report Necessary" with all progress reports and continuation requests.

(c) Use a Web page notice if your Web site contains HIV/AIDS educational information subject to the CDC content review guidelines.

4. Adhere to CDC policies for securing approval for CDC-sponsored conferences. If you plan to hold a conference, you must send a copy of the agenda to CDC's Grants Management Office.

5. If you plan to use materials using CDC's name, send a copy of the proposed material to CDC's Grants Management Office for approval.

VII. Agency Contacts

For general questions about this announcement, contact: Technical Information Management Section, CDC Procurement and Grants Office, 2920 Brandywine Road, MS K14, Atlanta, GA 30341, Telephone: 770–488–2700.

For program technical assistance, contact: Samuel Martinez, M.D., Health Scientist, CDC, NCHSTP, DHAP, IRS, 1600 Clifton Road, MS E58, Atlanta, GA 30333, Telephone: 404–639–5219, E-mail: *Sbm5@cdc.gov*.

For budget assistance, contact: Carlos Smiley, Grants Management Officer, CDC Procurement and Grants Office, 2920 Brandywine Road, MS K14, Atlanta, GA 30341, Telephone: 770–488–2722, E-mail: *anx3@cdc.gov*.

Dated: November 21, 2003.

Edward Schultz,

Acting Director, Procurement and Grants Office, Centers for Disease Control and Prevention.

[FR Doc. 03–29807 Filed 11–26–03; 11:20 am]

BILLING CODE 4163–18–P

appendix F

Sample Memorandum of Understanding

CAEAR Foundation (2005). Opening Doors: Linkages Training Manual. Linkage Worksheet #6: Your Sample MOU. www.caear.org/docs/worksheet6.pdf. Used with permission from the CAEAR Foundation.

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION FOUNDATION

Your Sample MOU

Use this worksheet as a template for what an MOU could look like between your agency and another collaborating partner.

Memorandum of Understanding

between

Crestview HIV Care Center (YOUR AGENCY) and Creekside Nutrition Center (REFERRAL AGENCY)

This agreement is entered between

Crestview HIV Care Center (YOUR AGENCY) and Creekside Nutrition Center (REFERRAL AGENCY)

Describe your mission:

Crestview HIV Care Center provides medical care and case management services for people in all stages of HIV disease.

Describe the other agency's mission:

Creekside Nutrition Center distributes food and cooked meals to people with limited financial resources and those who are too ill to prepare their own meals.

Summary

Crestview HIV Care Center (YOUR AGENCY) and Creekside Nutrition Center (REFERRAL AGENCY)

Agree to jointly collaborate on the HIV nutrition project (NAME OF PROJECT) an effort to increase linkages between

HIV care providers and providers of food in Mountain Valley. (FACILITIES/LOCATION)

As partners,

Crestview HIV Care Center (YOUR AGENCY) and Creekside Nutrition Center (REFERRAL AGENCY) agree to

work together to provide people with HIV/AIDS who can not afford food or are unable to cook for themselves with food and prepared meals.

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION FOUNDATION

Your Sample MOU continued

The parties propose to serve

People with HIV/AIDS in Mountain Valley whose nutritional needs are not being met.
DESCRIBE NATURE OF COLLABORATION

Responsibilities

Crestview HIV Care Center will YOUR AGENCY	Assess all clients nutritional needs and their resources to meet those needs Identify clients whose nutritional needs are not being met and provide them with information about the services of Creekside Nutrition Center Contact Creekside Nutrition Center's intake coordinator and schedule an intake appointment for each referred client Comply with all appropriate local, state, or Federal laws and regulations (Always include the compliance responsibility.)
Creekside Nutrition Center will REFERRAL PARTNER	Conduct intake sessions for all clients referred from Crestview HIV Care Center Develop a nutrition plan for each client and begin providing appropriate food and meal services Provide appropriate Crestview HIV Care Center case manager with information on services provided to each client. Refer clients with HIV who need medical and support services to Crestview HIV Care Center's intake coordinator and schedule an appointment for them as necessary Comply with all appropriate local, state, or Federal laws and regulations (Always include the compliance responsibility.)

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION FOUNDATION

Your Sample MOU continued

Time-line & Duration

This MOU shall remain in place from January 1, 2003 (STARTING DATE) until December 31, 2003 (ENDING DATE) unless modified in writing before that date. The MOU may be extended for Six months (LIST TIME PERIOD IN MONTHS OR YEARS)

Termination

This MOU may be terminated in whole or in part by either party without cause. The MOU will be deemed to be terminated 30 days after written notice of intent to terminate has been received by the other party. This notification must include the reason for termination. This MOU will terminate automatically if (LIST CONTINGENCIES)

Either agency ceases operations

In the event of termination, all required reports will be completed through the end of the agreement period.

Personnel

Staff governed by this MOU include (LIST STAFF TITLES/POSITIONS)

Crestview HIV Care Center	Case managers
	Intake coordinator
Creekside Nutrition Center	Intake coordinator

Points of contact for communication on this MOU will be

John Smith, case management director
CONTACT FOR YOUR AGENCY

Susan Wilson, intake coordinator
CONTACT FOR COLLABORATING AGENCY

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION FOUNDATION

Your Sample MOU continued

Reporting

Report will be submitted to each agency on a quarterly basis.
FREQUENCY

Crestview HIV Care Center will provide
YOUR AGENCY

the total number of clients referred to Creekside Nutrition Center's intake coordinator

Creekside Nutrition Center will provide
OTHER AGENCY

the number of intakes it performed for Crestview HIV Care Center clients, the number deemed eligible for services, and the number that enrolled.

Finances
LIST FINANCIAL ARRANGEMENTS, IF ANY. IF NONE, STATE SO.

Neither party will compensate the other for services performed

Confidentiality
DESCRIBE HOW CONFIDENTIALITY WILL BE PROTECTED BY EACH PARTY.

Both Crestview HIV Care Center and Creekside Nutrition Center have confidentiality policies (attached) governing client-related information and client files and both will adhere to their policies. Referrals will be made via telephone, but no names will be left on voicemails or sent via email. Quarterly reports will only contain aggregate numbers and no names.

Crestview HIV Care Center's case management director and Creekside Nutrition Center's intake coordinator will meet quarterly.

Clients names shall remain confidential as required by state and local law.

COMMUNITIES ADVOCATING EMERGENCY AIDS RELIEF
CAEAR COALITION FOUNDATION

Your Sample MOU continued

Communication

Andre Jackson, Executive Director, Crestview HIV Care Center and
YOUR AGENCY

Tammy Mills, Executive Director, Creekside Nutrition Center
COLLABORATING AGENCY

will participate in meetings on a quarterly basis.
FREQUENCY

These meetings will provide an opportunity to assess the referral linkages, review referral data and suggest necessary improvements. Other parties are also invited to participate in these meetings, as needed.

Signatures

YOUR AGENCY'S EXECUTIVE DIRECTOR	OTHER AGENCY'S EXECUTIVE DIRECTOR
LIST EXACT TITLE	LIST EXACT TITLE
YOUR AGENCY NAME	OTHER AGENCY NAME

appendix G

Ryan White HIV/AIDS Treatment Modernization Act
Parts A-F Explained

Part A: Funding to Metropolitan Areas Part A of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic.

Part A money goes to the chief elected official (CEO) of the major city or county government in the EMA or TGA. The CEO is legally the grantee, but usually chooses a department such as the health department or other entity to manage the grant. That entity is then referred to as the grantee. The grantee, working with a Part A planning council, manages the grant by making sure the funds are used correctly and all the rules about using Ryan White Part A funds are followed. Part A funds may be used for HIV primary medical care and other medical related and support services. A limited amount of Part A funds can be used for planning, managing, and evaluating programs, and for supporting the work of the planning council.

Part A grantees are required to use 75 percent of their award for core medical services and 25 percent for support services. These services may include:

Core services

- outpatient and ambulatory services
- AIDS pharmaceutical assistance
- oral health
- early intervention services
- health insurance premium
- cost sharing assistance for low-income individuals
- home health care
- medical nutrition therapy
- hospice services
- home and community-based health services
- mental health services; substance abuse outpatient care
- medical case management, including treatment adherence services

Support services

- outreach;
- medical transportation
- linguistic services;
- respite care for person caring for individuals with HIV/AIDS;
- referrals for health care and other support services;
- case management
- substance abuse residential services.

Ryan White core and support services are defined in Appendix VI.

Part B: State Funding; ADAP Part B provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five U.S. Pacific Territories or Associated Jurisdictions. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP Supplemental grants and grants to states for Emerging Communities - those reporting between 500 and 999 cumulative reported AIDS cases over the most recent 5 years.

Like Part A funds, Part B funds can be used for core medical and support services. A major priority is providing medications for people with HIV/AIDS. One of the key differences between Part A and B is that states awarded Part B funds decide how to spend the funds without planning council involvement, although many states get input from Part B planning groups. The Ryan White legislation gives states flexibility to deliver these services under five different Part B programs:

- The AIDS Drug Assistance Program (ADAP)
- Health insurance coverage
- Home and community-based care
- Services provided through consortia
- Direct services provided or contracted by the state

Part B providers may include public or nonprofit entities. For-profit entities are eligible only if they are the sole available providers of quality HIV care in the area.

Most states provide some services directly, but others work through subcontracts with Part B HIV Care Consortia. A consortium is an association of public and nonprofit health care and support service providers and community-based organizations that plans, develops, and delivers services for people living with HIV. Services provided through a consortium are considered support services.

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

The majority Part B and about one third of Ryan White funding is earmarked by Congress for the ADAP. Funding for ADAP is given to States based on that State's proportion of the nation's living AIDS cases.

The purpose of ADAP is to provide prescription drugs to eligible persons living with HIV. The drugs must be approved by the Food and Drug Administration. ADAPs can also use funds to pay to continue an eligible individual's private health insurance, if it has prescription drug coverage, or to fund treatment adherence programs for clients.

For an individual to receive ADAP assistance they must be medically diagnosed with HIV. They must qualify as "low income," as defined by the state. States receiving ADAP funding have the flexibility in designing their program, setting income and medical eligibility requirements and developing drug formularies. A drug formulary is a listing of all drugs funded by the state's ADAP.

Eligibility Each State and Territory establishes its own eligibility criteria. However, all States/Territories are required to implement an ADAP recertification process every six months to ensure only eligible clients are served. All States/Territories require that program participants document their HIV status. Clients must be low income, and under or uninsured. Also all ADAPs require that clients be residents in their state, and most require proof of residency.

Who receives ADAP funding? ADAP funding goes directly to the State/Territory. Community-based organizations can apply ADAP referral methodologies to funded Ryan White programs.

Part C: Early Intervention Services, Planning Grants & Capacity Development Part C of the Ryan White HIV/AIDS Treatment Modernization Act of 2006 has three funding areas: early intervention services, planning grants, and capacity development funding. Eligible applicants must be public or private nonprofit entities, including community and faith-based organizations, which are or intend to become comprehensive HIV primary care providers.

Early Intervention Services Part C Early Intervention Services (EIS) funds comprehensive, outpatient primary health care for people living with HIV over five cost categories: Early Intervention Services Costs, Core Medical Services Costs, Support Services Costs, Quality Management Costs, and Administrative Costs. Early Intervention Services Costs are those costs associated with the direct provision of medical care and make up at least 50 percent of a grantee budget. EIS Services Costs cover the following:

- Primary care providers
- Lab, x-ray, and other diagnostic tests
- Medical/dental equipment and supplies
- Medical case management
- Electronic medical records
- Patient education, in conjunction with medical care
- Transportation for clinical care provider staff to provide care
- Other clinical and diagnostic services regarding HIV/AIDS and periodic medical evaluations of individuals with HIV/AIDS

Core Medical Services Costs include those listed above, plus the following:

- HIV counseling
- AIDS Drug Assistance Program
- Health insurance premium and cost sharing assistance for low income individuals
- Home health care
- Hospice cervices
- Home and community-based health services (as defined under Part B)

Clinical Quality Management Costs are those costs required to maintain a clinical quality management program. Examples of these costs include:

- Continuous Quality Improvement (CQI) activities
- Clinical quality management coordination
- Data collection for clinical quality management purposes
- Consumer involvement to improve services
- Staff training/technical assistance to improve services

Support Services Costs, which are for services needed for individuals with HIV/AIDS to achieve their medical outcomes, include:

- Patient transportation to medical appointments
- Staff travel to provide support services
- Outreach to identify people with HIV, or at-risk of contracting HIV
- Translation and interpretation services
- Patient education materials
- Participation in Statewide Coordinated Statement of Need process
- Patient advocates to maintain access to care
- Respite care
- Some Administrative Costs covered under Part C include:
- Indirect costs
- Rent, utilities, and other facility support costs
- Personnel costs and fringe benefits
- Telecommunications, postage, office supplies
- Liability insurance
- Audits
- Payroll/Accounting services
- Computer hardware/software
- Program evaluation

Planning Grants Part C Planning Grants funds eligible entities to plan for the provision of high-quality comprehensive HIV primary health care services in rural or urban underserved areas and for communities of color. Planning grant funds are intended for a period of 1 year. Planning grants are available for one year and support the planning process; they do not fund any service delivery or patient care. Funded activities include:

- Identifying key stakeholders and bringing potential partners into the planning process
- Gathering a formal advisory group
- Conducting an in-depth review of the need for HIV primary care services in the community (including a local epidemiological profile, an evaluation of the community's service provider capacity, and a profile of the target population)
- Defining the components of care and forming essential program linkages with community providers
- Researching funding sources and applying for operational grants

Capacity Development Grants Capacity Development Grants are designed to help public and nonprofit entities strengthen their organizational infrastructure and enhance their capacity to provide access to HIV primary health care services in underserved or rural communities, and within all communities of color. Activities supported by this funding are short-term and include:

- Establishing and strengthening clinical, administrative, and managerial structures
- Developing a financial management unit
- Developing and implementing a clinical continuous quality improvement (CQI) program
- Applying for Medicaid certification and state clinic licensure
- Increasing the capability to oversee HIV service provision, including development of an organizational strategic plan for HIV care, education of Board members regarding the HIV program, and staff training and development regarding HIV care
- Purchasing clinical supplies and equipment for the purpose of developing, enhancing, or expanding HIV primary care services
- Developing an organizational strategic plan to address managed care changes or changes in the HIV epidemic in your community
- Developing a cultural competency training program

- Increasing the capability to implement and manage consumer involvement
- Developing a Patient Self Management support

Part D: Services for infants, children, youth, and women with HIV and their families Part D provides funds for family-centered care involving outpatient or ambulatory care for women, infants, children, and youth with HIV/AIDS. The main focus of Part D is to identify HIV positive pregnant women and ensure that they have access to prenatal care to prevent mother-to-child transmission of the virus. Grants are awarded competitively to public and private nonprofit organizations to provide primary and specialty care such as:

- Substance abuse counseling and treatment
- Mental health services
- Transportation
- Child care
- Housing assistance
- Care coordination
- Access to clinical trials and clinical research
- Support services
- Logistical support and coordination of services

Part F: Focused Program Areas
Part F includes three competitive grants: Special Projects of National Significance (SPNS); AIDS Education and Training Centers (AETCs); and the HIV/AIDS Dental Reimbursement Program.

Special Projects of National Significance (SPNS)

SPNS supports the development and replication of innovative models in HIV/AIDS care and service delivery to underserved populations diagnosed with HIV. The SPNS Program provides the mechanisms to:

- Quickly respond to emerging needs of individuals
- Fund special programs to develop standard electronic client information data systems
- To advance knowledge and skills in the delivery of health and support services to people with HIV who are underserved
- Support and assess the effectiveness of new innovative programs
- Fund innovative models of care and to support the development of effective delivery systems of HIV care and services
- Promote the sharing and replication of effective models of care

SPNS Initiatives include:

- Prevention with HIV-infected persons seen in primary care settings
- Evaluation of innovative methods for integrating substance abuse treatment in HIV primary care
- Development of outreach, care, and prevention strategies to engage HIV-positive young men who have sex with men of color
- Developing innovative models of care to provide oral health care to HIV-positive, underserved populations
- Enhancement and evaluation of existing health information electronic network systems for PLWHA in underserved communities
- Enhancement of linkages to HIV primary care in jail settings
- Capacity-building to develop standard electronic client information data systems

AIDS Education and Training Centers (AETCs)

AETCs are the clinical training component of Ryan White. AETCs seek to improve health outcomes of people living with HIV/AIDS through training on clinical management of HIV disease in such areas as use of antiretroviral therapies and prevention of HIV transmission. The program targets providers who treat minority, underserved, and vulnerable populations in communities hard hit by the HIV epidemic.

HIV/AIDS Dental Reimbursement Program

The Ryan White HIV/AIDS Dental Reimbursement Programs were created to address difficulties in access to dental care for persons living with HIV/AIDS. The programs provide funding for dental schools, postdoctoral dental programs and dental hygiene programs for the services they provide to uninsured individuals living with HIV/AIDS.

appendix H

Ryan White Program Definitions

Core Medical Services

Outpatient/Ambulatory medical care (health services) is the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, or nurse practitioner in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not outpatient settings. Services includes diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's guidelines. Such care must include access to antiretroviral and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination antiretroviral therapies. NOTE: Early Intervention Services provided by Ryan White Part C and Part D Programs should be included here under Outpatient/ Ambulatory medical care.

AIDS Drug Assistance Program (ADAP treatments) is a State-administered program authorized under Part B of the Ryan White Program that provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance, Medicaid, or Medicare.

AIDS Pharmaceutical Assistance (local) includes local pharmacy assistance programs implemented by Part A or Part B Grantees to provide HIV/AIDS medications to clients. This assistance can be funded with Part A grant funds and/or Part B base award funds. Local pharmacy assistance programs are not funded with ADAP earmark funding.

Oral health care includes diagnostic, preventive, and therapeutic services provided by general dental practitioners, dental specialists, dental hygienists and auxiliaries, and other trained primary care providers.

Early intervention services (EIS) include counseling individuals with respect to HIV/AIDS; testing (including tests to confirm the presence of the disease, tests to diagnose to extent of immune deficiency, tests to provide information on appropriate therapeutic measures); referrals; other clinical and diagnostic services regarding HIV/AIDS; periodic medical evaluations for individuals with HIV/ AIDS; and providing therapeutic measures.

Health Insurance Premium & Cost Sharing Assistance is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.

Home Health Care includes the provision of services in the home by licensed health care workers such as nurses and the administration of intravenous and aerosolized treatment, parental feeding, diagnostic testing, and other medical therapies.

Home and Community-based Health Services include skilled health services furnished to the individual in the individual's home based on a written plan of care established by a case management team that includes appropriate health care professionals. Services include durable medical equipment; home health aide services and personal care services in the home; day treatment or other partial hospitalization services; home intravenous and aerosolized drug therapy (including prescription drugs administered as part of such therapy); routine diagnostics testing administered in the home; and appropriate mental health, developmental, and rehabilitation services. Inpatient hospitals services, nursing home and other long term care facilities are NOT included.

Hospice services include room, board, nursing care, counseling, physician services, and palliative therapeutics provided to clients in the terminal stages of illness in a residential setting, including a non-acute-care section of a hospital that has been designated and staffed to provide hospice services for terminal clients.

Mental health services are psychological and psychiatric treatment and counseling services offered to individuals with a diagnosed mental illness, conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.

Medical nutrition therapy is provided by a licensed registered dietitian outside of a primary care visit and includes the provision of nutritional supplements. Medical nutrition therapy provided by someone other than a licensed/registered dietitian should be recorded under psychosocial support services.

Medical Case management services (including treatment adherence) are a range of client-centered services that link clients with health care, psychosocial, and other services. The coordination and follow-up of medical treatments is a component of medical case management. These services ensure timely and coordinated access to medically appropriate levels of health and support services and continuity of care, through ongoing assessment of the client's and other key family members' needs and personal support systems. Medical case management includes the provision of treatment adherence counseling to ensure readiness for, and adherence to, complex HIV/AIDS treatments. Key activities include (1) initial assessment of service needs; (2) development of a comprehensive, individualized service plan; (3) coordination of services required to implement the plan; (4) client monitoring to assess the efficacy of the plan; and (5) periodic re-evaluation and adaptation of the plan as necessary over the life of the client. It includes client-specific advocacy and/or review of utilization of services. This includes all types of case management including face-to-face, phone contact, and any other forms of communication.

Substance abuse services outpatient is the provision of medical or other treatment and/or counseling to address substance abuse problems (i.e., alcohol and/or legal and illegal drugs) in an outpatient setting, rendered by a physician or under the supervision of a physician, or by other qualified personnel.

Core Support Services

Case Management (non-medical) includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments, as medical case management does.

Child care services are the provision of care for the children of clients who are HIV-positive while the clients attend medical or other appointments or Ryan White Program-related meetings, groups, or training. ***NOTE: This does not include child care while a client is at work.***

Pediatric* developmental assessment and early intervention *services are the provision of professional early interventions by physicians, developmental psychologists, educators, and others in the psychosocial and intellectual development of infants and children. These services involve the assessment of an infant's or child's developmental status and needs in relation to the involvement with the education system, including early assessment of educational intervention services. It includes comprehensive assessment of infants and children, taking into account the effects of chronic conditions associated with HIV, drug exposure, and other factors. Provision of information about access to Head Start services, appropriate educational settings for HIV-affected clients, and education/assistance to schools should also be reported in this category.

Emergency financial assistance is the provision of short-term payments to agencies or establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication when other resources are not available.

Food bank/home-delivered meals include the provision of actual food or meals. It does not include finances to purchase food or meals. The provision of essential household supplies such as hygiene items and household cleaning supplies should be included in this item. Includes vouchers to purchase food.

Health education/risk reduction is the provision of services that educate clients with HIV about HIV transmission and how to reduce the risk of HIV transmission. It includes the provision of information; including information dissemination about medical and psychosocial support services and counseling to help clients with HIV improve their health status.

Housing services are the provision of short-term assistance to support emergency, temporary or transitional housing to enable an individual or family to gain or maintain medical care. Housing-related referral services include assessment, search, placement, advocacy, and the fees associated with them. Eligible housing can include both housing that does not provide direct medical or supportive services and housing that provides some type of medical or supportive services such as residential mental health services, foster care, or assisted living residential services.

Legal services are the provision of services to individuals with respect to powers of attorney, do-not-resuscitate orders and interventions necessary to ensure access to eligible benefits, including discrimination or breach of confidentiality litigation as it relates to services eligible for funding under the Ryan White Program. It does not include any legal services that arrange for guardianship or adoption of children after the death of their normal caregiver.

Linguistics services include the provision of interpretation and translation services.

Medical transportation services include conveyance services provided, directly or through voucher, to a client so that he or she may access health care services.

Outreach services are programs that have as their principal purpose identification of people with unknown HIV disease or those who know their status so that they may become aware of, and may be enrolled in care and treatment services (i.e., case finding), not HIV counseling and testing nor HIV prevention education. These services may target high-risk communities or individuals. Outreach programs must be planned and delivered in coordination with local HIV prevention outreach programs to avoid duplication of effort; be targeted to populations known through local epidemiologic data to be at disproportionate risk for HIV infection; be conducted at times and in places where there is a high probability that individuals with HIV infection will be reached; and be designed with quantified program reporting that will accommodate local effectiveness evaluation.

Permanency planning is the provision of services to help clients or families make decisions about placement and care of minor children after the parents/caregivers are deceased or are no longer able to care for them.

Psychosocial support services are the provision of support and counseling activities, child abuse and neglect counseling, HIV support groups, pastoral care, caregiver support, and bereavement counseling. Includes nutrition counseling provided by a non-registered dietitian but excludes the provision of nutritional supplements.

Referral for health care/supportive services is the act of directing a client to a service in person or through telephone, written, or other type of communication. Referrals may be made within the non-medical case management system by professional case managers, informally through support staff, or as part of an outreach program.

Rehabilitation services are services provided by a licensed or authorized professional in accordance with an individualized plan of care intended to improve or maintain a client's quality of life and optimal capacity for self-care. Services include physical and occupational therapy, speech pathology, and low-vision training.

Respite care is the provision of community or home-based, non-medical assistance designed to relieve the primary caregiver responsible for providing day-to-day care of a client with HIV/AIDS.

Substance abuse services–residential is the provision of treatment to address substance abuse problems (including alcohol and/or legal and illegal drugs) in a residential health service setting (short-term).

Treatment adherence counseling is the provision of counseling or special programs to ensure readiness for, and adherence to, complex HIV/AIDS treatments by non-medical personnel outside of the medical case management and clinical setting.

appendix I

Other Government Resource and Technical Assistance Opportunites

Office of Public Health and Science (OPHS)
The Office of Public Health and Science (OPHS, www.hhs.gov/ophs) is made up of 12 core public health offices and the Commissioned Corps, a uniformed service of more than 6,000 health professionals who serve at HHS and other federal agencies.

HIV/AIDS Related Offices and Initiatives
The offices under OPHS offer a range of resources, trainings, technical assistance and funding opportunities in public health. Several offices have HIV/AIDS awareness building programs and organizational capacity building initiatives. There are key OPHS offices that also have Minority AIDS Initiative (MAI) funding that they are responsible for distributing funds to grantees serving ethnic minority communities hardest hit by HIV/AIDS. The following are the key offices under OPHS that have HIV/AIDS specific technical assistance resources and MAI funding:

Office of HIV/AIDS Policy (OHAP) is the primary clearinghouse for all HHS efforts in the area of HIV/AIDS. OHAP advises senior HHS officials on the development and implementation of HIV/AIDS policy and the implementation of HIV/AIDS programs across HHS agencies. OHAP also sponsors the National HIV Testing Mobilization Campaign (NHTMC), a nationwide effort to promote HIV testing. Learn more about OHAP technical assistance opportunities at www.hhs.gov/ophs/ohap.

Office of Minority Health (OMH) is the federal focal point for addressing the health status and quality of life for racial and ethnic minority populations in the U.S. OMH coordinates special initiatives targeting minorities, including the HHS Minority HIV/AIDS Initiative, the HHS Disparities Initiative, the White House Initiative on Historically Black Colleges and Universities, the White House Initiative on Educational Excellence for Hispanic Americans, and the White House Initiative on Tribal Colleges and Universities (read about these at www.omhrc.gov).

Office on Women's Health (OWH) strives to improve the health of American women by advancing and coordinating a comprehensive women's health agenda throughout HHS. OWH runs a number of HIV/AIDS programs, which are described on their Web site at www.womenshealth.gov/owh.

Office of Population Affairs (OPA) advises the Secretary and the Assistant Secretary for Health on a wide range of reproductive health topics, including adolescent pregnancy, family planning, and other population issues. OPA has three initiatives, 1) Parents Speak up National Campaign, 2) HIV Prevention Integration Initiative, and 3) Male Involvement Initiative. You can find out about these initiatives and opportunities for your organization at www.hhs.gov/opa.

Special Populations and Initiatives

White House Faith-Based & Community Initiative

The White House Office of Faith-based and Community Initiatives and Centers for Faith-Based and Community Initiatives in eleven federal agencies were created to help strengthen and expand the role of faith-based community organizations (FBCOs) in providing social services. The initiative's Web site (www.whitehouse.gov/government/fbci) provides information on publications and technical assistance opportunities to help your organization navigate the federal grants system.

Focus of the Initiative

- Identifying and eliminating barriers that impede the full participation of FBCOs in the federal grants process
- Ensuring that federally-funded social services administered by state and local governments are consistent with equal treatment provisions
- Encouraging greater corporate and philanthropic support for FBCOs' social service programs through public education and outreach activities
- Pursuing legislative efforts to extend charitable choice provisions that prevent discrimination against faith-based organizations, protect the religious freedom of beneficiaries, and preserve religious hiring rights of faith-based charities

Indian Health Services

The Indian Health Services' (IHS, www.ihs.gov) mission is to promote the physical, mental, social, and spiritual health of American Indians and Alaska Natives (AI/AN). The IHS' goal is to assure that comprehensive, culturally acceptable public health services are available for American Indian and Alaska Native communities.

IHS HIV/AIDS Program

The IHS HIV/AIDS Program (www.ihs.gov/MedicalPrograms/HIVAIDS) includes HIV/AIDS prevention and treatment services provided by all IHS local health service programs, with the goals of:

- Helping AI/AN individuals become aware of their HIV status
- Reducing the number of new AI/AN HIV infections annually
- Reducing HIV transmission in the community through prevention education
- Ensuring access to quality health services for AI/AN individuals and families living with HIV/AIDS
- Forming sustainable collaborations to maximize resources for American Indian and Alaska Native HIV/AIDS prevention and treatment

Glossary of HIV/AIDS Terms[3]

AIDS Drug Assistance Program (ADAP)
Administered by States and authorized under Part B of the Ryan White HIV/AIDS Treatment Modernization Act. Provides FDA-approved medications to low-income individuals with HIV disease who have limited or no coverage from private insurance or Medicaid. ADAP funds may also be used to purchase insurance for uninsured Ryan White HIV/AIDS Program clients as long as the insurance costs do not exceed the cost of drugs through ADAP, and the drugs available through the insurance program at least match those offered through ADAP.

Administrative or Fiscal Agent
Entity that functions to assist a grantee, consortium, or other planning body in carrying out administrative activities (e.g., disbursing program funds, developing reimbursement and accounting systems, developing Requests for Proposals (RFPs), monitoring contracts).

AETC (see Appendix V, Part F)

Acquired Immunodeficiency Syndrome (AIDS)
A disease caused by the human immunodeficiency virus.

Antiretroviral
A substance that fights against a retrovirus, such as HIV.

AIDS service organization (ASO)
An organization that provides primary medical care and/or support services to populations infected with and affected by HIV disease.

Capacity
Core competencies that substantially contribute to an organization's ability to deliver effective HIV/AIDS primary medical care and health-related support services. Capacity development activities should increase access to the HIV/AIDS service system and reduce disparities in care among underserved people living with HIV/AIDS.

Ryan White Comprehensive AIDS Resources Emergency Act (CARE Act)
Federal legislation created to address the unmet health care and service needs of people living with HIV Disease (PLWH) and their families. It was enacted in 1990 and reauthorized in 1996 and 2000. The CARE Act was reauthorized in 2006 as the Ryan White HIV/AIDS Treatment Modernization Act.

Community-based organization (CBO)
An organization that provides services to locally defined populations.

Centers for Disease Control and Prevention (CDC)
Federal agency within HHS that administers disease prevention programs, including HIV/AIDS prevention.

Chief Elected Official (CEO)
The official recipient of Part A or Part B Ryan White HIV/AIDS Program funds. For Part A, this is usually a city mayor, county executive, or chair of the county board of supervisors. For Part B, this is usually the governor. The CEO is ultimately responsible for administering all aspects of their title's CARE Act funds and ensuring that all legal requirements are met.

Centers for Medicare and Medicaid Services (CMS)
Federal agency within HHS that administers the Medicaid, Medicare, State Child Health Insurance Program (SCHIP), and the Health Insurance Portability and Accountability Act (HIPAA).

Community Forum or Public Meeting
A small-group method of collecting information from community members in which a community meeting is used to provide a directed but highly interactive discussion. Similar to but less formal than a focus group, it usually includes a larger group; participants are often self-selected (i.e., not randomly selected to attend).

Comprehensive Planning
The process of determining the organization and delivery of HIV services. This strategy is used by planning bodies to improve decision-making about services and maintain a continuum of care for people living with HIV/AIDS.

Community Health Centers
Federally-funded by HRSA's Bureau of Primary Health Care, centers provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities.

Consortium/HIV Care Consortium
A regional or statewide planning entity established by many state grantees under Part B of the Ryan White HIV/AIDS Program to plan and sometimes administer Part B services. An association of health care and support service agencies serving people living with HIV/AIDS under Part B.

Continuum of Care
An approach that helps communities plan for and provide a full range of emergency and long-term service resources to address the various needs of people living with HIV/AIDS.

3 Many of the terms included in this glossary were taken from HRSA's The HIV/AIDS Program: Glossary of Terms, http://hab.hrsa.gov/history/webterms.htm.

Cultural Competence
The knowledge, understanding, and skills to work effectively with individuals from differing cultural backgrounds.

Early Intervention Services (EIS)
Activities designed to identify individuals who are HIV-positive and get them into care as quickly as possible. As funded through Parts A and B of the Ryan White HIV/AIDS Program, includes outreach, counseling and testing, information and referral services. Under Part C of the Ryan White HIV/AIDS Program, EIS also include comprehensive primary medical care for individuals living with HIV/AIDS.

Eligible Metropolitan Area (EMA)
Geographic areas highly impacted by HIV/AIDS that are eligible to receive Ryan White HIV/AIDS Program Part A funds. To be an eligible EMA, an area must have reported more than 2,000 AIDS cases in the most recent 5 years and have a population of at least 50,000.

Epidemic
A disease that occurs clearly in excess of normal expectation and spreads rapidly through a demographic segment of the human population. Epidemic diseases can be spread from person to person, or from a contaminated source such as food or water.

Epidemiology
The branch of medical science that studies the incidence, distribution, and control of disease in a population.

Family Centered Care
A model in which systems of care under Ryan White Part D are designed to address the needs of people living with HIV/AIDS and affected family members as a unit, providing or arranging for a full range of services. Family structures may range from the traditional, biological family unit to non-traditional family units with partners, significant others, and unrelated caregivers.

Grantee
The recipient of Ryan White HIV/AIDS Program funds responsible for administering the award.

Health Insurance Continuity Program (HICP)
A program primarily under Part B of the Ryan White HIV/AIDS Program that makes premium payments, co-payments, deductibles, and/or risk pool payments on behalf of a client to purchase/maintain health insurance coverage.

HIV/AIDS Bureau (HAB)
The bureau within HRSA that is responsible for administering the Ryan White HIV/AIDS Treatment Modernization Act.

HIV/AIDS Dental Reimbursement Program
The program within the HAB's Division of Community Based Programs that assists with uncompensated costs incurred in providing oral health treatment to people living with HIV/AIDS.

HIV Disease
Any signs, symptoms, or other adverse health effects due to the human immunodeficiency virus.

Home and Community Based Care
A category of eligible services that states may fund under Part B of the Ryan White HIV/AIDS Program.

Health Resources and Services Administration (HRSA)
The agency within HHS that administers various primary care programs for the medically underserved, including the Ryan White HIV/AIDS Program.

Injection Drug User (IDU)

Lead Agency
The agency within a Part B consortium that is responsible for contract administration; also called a fiscal agent (an incorporated consortium sometimes serves as the lead agency).

Minority AIDS Initiative (MAI)
An HHS initiative that provides special resources to reduce the spread of HIV/AIDS and improve health outcomes for people living with HIV/AIDS within communities of color. Enacted to address the disproportionate impact of the disease in such communities. Formerly referred to as the Congressional Black Caucus Initiative because of that body's leadership in its development.

Needs Assessment
A process of collecting information about the needs of people living with HIV/AIDS (both those receiving care and those not in care), identifying current resources (Ryan White HIV/AIDS Program and other) available to meet those needs, and determining what gaps in care exist.

Part A
The part of the Ryan White HIV/AIDS Program that provides emergency assistance to EMAs disproportionately affected by the HIV/AIDS epidemic.

Part B
The part of the Ryan White HIV/AIDS Program that provides funds to states and territories for primary health care (including HIV treatments through ADAP) and support services that enhance access to care for people living with HIV/AIDS and their families.

Part C
The part of the Ryan White HIV/AIDS Program that supports outpatient primary medical care and early intervention services to people living with HIV/AIDS through grants to public and private non-profit organizations. Part C also funds capacity development and planning grants to prepare programs to provide EIS services.

Part D
The part of the Ryan White HIV/AIDS Program that supports coordinated services and access to research for children, youth, and women with HIV disease and their families.

Part F - AIDS Education and Training Centers (AETCs)
Regional centers providing education and training for primary care professionals and other AIDS-related personnel. AETCs are authorized under Part F of the Ryan White HIV/AIDS Program and administered by the HRSA HIV/AIDS Bureau's Division of Training and Technical Assistance (DTTA).

Part F - Special Projects of National Significance (SPNS)
A health services demonstration, research, and evaluation program funded under Part F of the Ryan White HIV/AIDS Program to identify innovative models of HIV care. SPNS projects are awarded competitively.

Planning Council
A planning body appointed or established by the Chief Elected Official of an EMA whose basic function is to assess needs, establish a plan for the delivery of HIV care in the EMA, and establish priorities for the use of Ryan White HIV/AIDS Program Part A funds.

Planning Process
Steps taken and methods used to collect information, analyze and interpret it, set priorities, and prepare a plan for rational decision making.

PLWHA (People Living with HIV/AIDS)

Priority Setting
The process used to establish priorities among service categories, to ensure consistency with locally identified needs, and to address how best to meet each priority.

Quality
The degree to which a health or social service meets or exceeds established professional standards and user expectations.

Quality Assurance (QA)
The process of identifying problems in service delivery, designing activities to overcome these problems, and following up to ensure that no new problems have developed and that corrective actions have been effective. The emphasis is on meeting minimum standards of care.

Request for Proposals (RFP)
An open and competitive process for selecting providers of services (sometimes called a Request for Application or RFA).

Resource Allocation
The responsibility of the Part A planning council to assign Ryan White HIV/AIDS Program amounts or percentages to established priorities across specific service categories, geographic areas, populations, or subpopulations.

Ryan White HIV/AIDS Treatment Modernization Act of 2006 (Ryan White Program)
Enacted in 2006, this legislation reauthorized the Ryan White Program, formerly called the Ryan White CARE Act.

Statewide Coordinated Statement of Need (SCSN)
A written statement of need for the entire state developed through a process designed to collaboratively identify significant HIV issues and maximize Ryan White HIV/AIDS Program coordination. The SCSN process is convened by the Part B grantee, with equal responsibility and input by all programs.

Section 340B Drug Discount Program
A program administered by the HRSA's Bureau of Primary Care, Office of Pharmacy Affairs established by Section 340B of the Veteran's Health Care Act of 1992, which limits the cost of drugs to Federal purchasers and to certain grantees of Federal agencies.

Service Gaps
All the service needs of PLWHA, except for the need for primary health care for individuals who know their status but are not in care. Service gaps include additional need for primary health care for those already receiving primary medical care.

STD (Sexually Transmitted Disease)

Technical Assistance (TA)
The delivery of practical program and technical support to the CARE Act community. TA is to assist grantees, planning bodies, and affected communities in designing, implementing, and evaluating Ryan White - supported planning and primary care service delivery systems.

Transitional Grant Area (TGA)
Designation under Part A of the Ryan White Program. To be eligible as a TGA, an area must have reported at least 1,000, but fewer than 2,000 new AIDS cases in the most recent 5 years.

Target Population
A population to be reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics.